Religion and Mental Health: Issues for Professionals and Public

Lakshman Ganatra

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology.

Coventry University, Faculty of Health and Life Sciences

and

University of Warwick, Department of Psychology

May 2017

Contents

List of Tables

List of Figures

List of Abbreviations

Abbreviation	*Explanation*
ANOVA	Analysis of Variance
BOS	Bristol Online Surveys
BPS	British Psychological Society
BRS	Brief Resilience Scale
CBT	Cognitive Behavioural Therapy
MANOVA	Multivariate Analysis of Variance
MMRS	Multi-Dimensional Measure of Religiosity/Spirituality
NICE	National Institute for Health and Care Excellence
NIMHE	National Institute for Mental Health in England
NHS	National Health Service
NRG	Non-Religious Group
ONS	Office of National Statistics
PHQ-9	Patient Health Questionnaire
PRISMA	Preferred Reported Items for Systematic Review and Meta-Analyses
RG	Religious Group
R/S	Religiosity/Spirituality
SCS	Suicide Cognitions Scale
SBQ-R	Suicide Behaviours Questionnaire Revised
WHO	World Health Organisation
WHOQOL-BREF	WHO Quality of Life Scale

List of Appendices

Acknowledgements

Firstly, I would like to thank my supervisor Tony Colombo, whose endless patience and guidance made this project possible. Tony went beyond his duty as a supervisor for my project and also helped me throughout the three years on the course. His support and expertise not only helped guide the project, but also my career as a Clinical Psychologist.

Also I would like to acknowledge the great help and support of my appraisal tutor Jo Kucharska. Over the three years she has helped my personal development and supported me through difficult times. I am grateful to have had her as an appraisal tutor. I would also like to thank all the course team who have supported my education and development as a Clinical Psychologist and I feel privileged to have been part of the Coventry and Warwick course. Also, I am grateful to my placement supervisors over the last three years; all of whom have been extremely encouraging and sympathetic. I feel fortunate to have worked with them and learn from them.

I would also like to thank Yashaswi Upadhyay, who has been a wonderful research assistant, and has had to deal with my constant nagging. I am extremely grateful for her hard work and contributions to the project. Also, a big thanks to Anishaa Padhiar for her hard work in designing my research poster. I wish them both all the best with their degree and future career.

I am extremely grateful to my family who have supported me throughout my life and especially over the last three years. Despite being far away, they have always been there for me.

My time on the course would have not been nearly as enjoyable without my peers. Over the three years, I have made strong friendships and bonds and feel honoured to have been on this journey with them. I wish each and every one of them a prosperous future and hope to continue working closely with them after the course.

I am grateful to all those who took the time to participate in my study; you have not only contributed to important research, but have also supported my career.

Declaration

This thesis was carried out under the supervision of Dr Anthony Colombo (Clinical Psychology Doctorate, Coventry University), who was involved in developing the original research ideas and has provided support with statistical analysis, suggestions and feedback throughout; including reading drafts of the chapters. Yashaswi Upadhyay (BSc Psychology Student, Coventry University) provided support as a research assistant, specifically acting as a second-rater for the literature review analysis. Anishaa Padhiar (BA Interior Design Student, Coventry University) designed the research poster used for advertisement. Draft papers were also read by Jo Kucharska (Clinical Psychology Doctorate, Coventry University).

Other than these collaborations, this thesis is my own work and has not been submitted for any other degree or to any other institution.

Chapter one (Literature review) has been prepared for submission to *Mental Health, Religion & Culture*. Chapter two (Empirical paper) has been prepared for submission to *Suicide and Life-Threatening Behavior*. Both papers will be submitted under the authorship of myself and the research supervisor.

Summary

This thesis is structured as three chapters which explore the subject of religion and mental health for both professionals and public.

Chapter one reviews the published literature examining professional's engagement with religion within the mental health system in the United Kingdom. Evidence suggests that professionals view religion as important in mental health care, however a number of key fundamental barriers at the macro- and micro-level influence engagement. Barriers include lack of engagement within the corporate context; ethical considerations and dilemmas in clinical practice; and issues in daily practice. Professionals require stronger guidance to feel supported. Training institutions need to address religion within teaching and organisations must be aware of the ethical dilemma professionals face.

Chapter two presents an empirical study examining the influence psychosocial forces of religiosity and spirituality have on suicide. The study was in the form of a cross-sectional e-survey design using a range of psychometrically valid self-report measures. A general population sample of 231 participants from different faith and non-faith backgrounds participated. Results found that religious participants had higher levels of depression and suicidal thoughts that non-religious participants. However, differences were not found between groups, suggesting that it is not belief systems per se, but other psycho-social factors which are more important. Religious participants were found to have higher levels of religiosity and spirituality, moreover, negative religious coping and forgiveness appear to have a significant influence on psychological

distress. Implications of the findings are discussed, along with suggestions for future research.

Chapter three provides reflections on the research process and my personal and professional development through the course.

Overall Word Count: 19,111

(Excluding: tables, figures, references and appendices)

Chapter 1: Literature Review Paper

Professional engagement with religiosity and spirituality within mental health practice in the UK: A Systematic Review of the Literature.

Chapter Word Count: 7977

(excluding tables, figures and references)

Prepared for submission to:

Mental Health, Religion & Culture

(see Appendix A for author guidelines)

1.1. Abstract

A systematic review of empirical literature examined religiosity/spirituality in mental health practice in the United Kingdom. The search was conducted in accordance with PRISMA guidelines; which yielded 17 studies for inclusion. Studies were analysed using a thematic synthesis approach. Findings relate to barriers that prevent professionals from engaging with R/S and are organised around three themes. The first explores lack of engagement within the corporate context. The second explores ethical considerations and dilemmas of R/S in clinical practice. The last explores issues in daily practice. Professionals view R/S as important within mental health, however barriers, both at macro- and micro-level influence professional engagement. More definition and commitment from professional bodies and corporate structures would enable staff to feel supported. Training institutions need to address the lack of R/S in teaching. Organisations need to be aware of ethical dilemma of professionals and should examine the boundaries and ethics of R/S in practice.

Keywords: Religion, Spirituality, Professionals, Mental Health, Practice, UK

1.2. Introduction

1.2.1. Religiosity/Spirituality and Mental Health Practice in the UK

While the majority of the UK population consider themselves to be Christian (Office for National Statistics [ONS], 2011), it is a multicultural society with a rich history of diverse religious backgrounds, including Muslim, Jewish, Hindu and Sikh (Boehnlein, 2008).

Similar levels of religiosity/spirituality (R/S) can be found within the mental health population; with over 50% of mental health service users report holding religious or spiritual beliefs (Mental Health Foundation, 1997). In acknowledgement of this, the National Institute for Mental Health in England (NIMHE) set up a Spirituality and Mental Health project in 2001, whereby different faith communities and mental health professionals came together to collaborate and develop inter-professional guidelines (Gilbert, 2007). The aim of this was to provide input support into the workforce and help professionals recognise the importance and impact of R/S to patients.

Service users have widely commented on the importance and desire to discuss religious and spiritual issues within their care (Bellamy *et al.,* 2007; Mental Health Foundation, 2007); seeing it as an essential aspect of their well-being (Schrank & Slade, 2007). Thousands of studies worldwide have examined the relationship between R/S and mental health (Behere, Das, Yadav & Behere, 2013), however, little of this research has been conducted in the UK (Dein, 2010).

Despite the cultural overlap between countries like the North America, Continental Europe and the UK, there are clear disparities in the healthcare

systems and training of professionals (Bhugra, 2016). In particular, differences in mental health care between the NHS and other countries have been highlighted (Berry, 2015). These disparities are often reflected in areas such as ethical codes of conduct (Leach & Harbin, 1997) and professional training (Zisook *et al.,* 2007). Mental health services in England traditionally comprise of multi-disciplinary professionals including Psychiatrists, Psychologists, Community Psychiatric Nurses, Social Workers and Occupational Therapists (Gilburt, 2015); recent transformations in mental health policy also recognise counsellors and primary care practitioners as front line staff (Gilburt *et al.,* 2014).

1.2.2. Religiosity/Spirituality and Positive Mental Health

Numerous studies over the last few decades have identified positive associations between R/S and health (Moreira-Almeida, Neto & Koenig, 2006). Research supporting this stems from cross-sectional and longitudinal studies (George *et al.,* 2000; Plante & Sherman, 2001). The role of R/S in promoting health outcomes has been widely accepted into mainstream health models (Puchalski, 2001). The Fetzer Institute noted that religion and spirituality can provide caring communities for those who are unwell (Laudet, Morgen & White, 2006), and protect against disease through patterns of beliefs and sanctions against excessive behaviour (e.g. smoking, drinking, drug taking etc.) (Cook, Goddard & Westall, 1997).

Connections can also be found in mental health, where high levels of R/S amongst service users has been associated with successful stress management, positive coping strategies and supportive social environments (Behere, Das, Yadav & Behere, 2013) less depression (Koenig, 2007) and

lower rates of suicide (van Praag, 2009). Psychological models have suggested that positive cognitive appraisals, increased social support and healthy lifestyles are associated with religion and prayer (Dein, 2006). Furthermore, attributes such as altruism and gratitude (Schwartz, 2003) hope and optimism (Koenig, 2009) have been reported as mediating factors, improving well-being. Some studies have suggested that positive mental health is not directly attributed to religion, but other factors such as hobbies, interest and social support (Johansson, 2008). Conversely, negative associations such as guilt and dependency (Dein & Littlewood, 2005) abandonment, punishment and anger (Pargament, 2010) have been correlated with poor mental health.

1.2.3. Incorporating Religiosity/Spirituality into Mental Health Practice

Elements of R/S have already been integrated with treatments for mental health (Hefti, 2011) and have shown positive benefits. For example, Mindfulness originates from Buddhist teachings (Kabat-Zinn, 2003) and has a strong evidence base for the treatment and prevention of relapse of depression. A recent review of faith-based treatments for mental health difficulties found that faith-adapted CBT was largely found to outperform standard CBT or control conditions for both depression and anxiety (Anderson, Heywood-Everett, Siddiqi, Wright, Meredith & McMillan, 2015).

In non-western societies, R/S are frequently incorporated into treatments (Ramakrishnan *et al.,* 2014) with much more integration of care and community; whereby religious leaders are often approached before health professionals. It has been suggested that incorporating patient's beliefs

contributes to therapeutic alliance and engagement which in turn improves outcomes (Dein, 2004).

With the growing evidence, guidelines for many professional groups suggest that treatments should respect and incorporate the patient's wishes and beliefs (National Institute for Health and Clinical Excellence, 2010), including seeking the advice of an appropriate religious or community leader. Treatments should be adapted to the population needs (van Loon *et al.,* 2013) and be culturally sensitive.

Despite the evidence for the role of religion and spirituality in health outcomes, there appear to be divided views amongst health care professionals, especially that of mental health professionals (Moreira-Almeida, Neto & Koenig, 2006). Suggestions to incorporate R/S in psychiatric care provoked controversy and widespread debate as no guidance had been given on how this could be done (Cook, 2004). Many professionals have debated concerns around the potential harm of religion and spirituality (Cook, Powell, Sims & Eagger, 2011), difficulties in knowing how to incorporate it and maintaining boundaries (Griffith, 2010) as well as a lack of confidence/knowledge in dealing with issues within practice (Cook, Powell, Sims & Eagger, 2011).

1.2.4. Rationale

Despite the large body of research demonstrating the influence of R/S in health and mental health outcomes (Behere, Das, Yadav & Behere, 2013), it is still regularly overlooked within mental health care (Crossley & Salter, 2005). It is important to consider the implications of R/S within mental health care in the UK. Mental health practice exists through the professionals that deliver

services; in order to gain a clearer understanding of R/S for patients, we need to understand how professionals contextualise perspectives on R/S.

1.2.4.1. Aim

The aim of this systematic review of the literature is to examine the role and influence of R/S in mental health practice in the UK. In order to examine this, the principal question driving the systematic review literature is:

How do mental health professionals engage with the notions of religiosity and spirituality during clinical practice?

1.3. Method

1.3.1. Search Strategy

Ethical approval was granted by Coventry University Ethics Committee (see appendix B). The process of study selection was prepared in accordance with the "Preferred Reported Items for Systematic Review and Meta-Analyses" (PRISMA) guidelines (Moher *et al.,* 2009). A search of the literature for original research studies that have explored the role and influence of R/S in mental health professionals practice within the UK was carried out in March 2017.

Selection of databases for use was informed by a review of mental health and religion (Wright *et al.,* 2014), if available through the university access system. Databases included PsychINFO, PsycArticles, PubMed, Cumulative Index to Nursing and Allied Health (CINAHL), Scopus, Web of Science, Academic Search Complete. A search of grey literature was also conducted using Google Scholar and EThOS.

1.3.2. Search Terms

Three broad search concepts were used: (1) Religion or spirituality; (2) Mental Health Professionals and (3) Mental Health Practice. Table 1.1 presents an overview of the key search terms used including the variations. The search involved using the Boolean operators AND, OR, NOT in various combinations to capture the full breadth of coverage in the search.

Concept	Variation	Location
Religion or Spirituality	A. Relig* B. Spiritual*	Title and Abstract
"Mental Health Professional"	A. Psychiatrists? B. Psychologists? C. Nurses? D. Social Workers? E. OT? F. Practitioners? G. Doctors? H. Therapists? I. Counsellors? J. Clinicians? K. Personnel	Full Text
"Mental Health Practice"	A. Treatment? B. Intervention? C. Management? D. Care? E. Training? F. Clinical Practice? G. Services? H. Therapy / psychotherapy?	Full Text

Table 1.1. Systematic Review Search Terms

*Note: Search terms performed using * to truncate keywords to capture all variations; ? denotes the use of a thesaurus to capture variations of meanings and terms, including English/American terms, exploded and major terms.*

1.3.3. Initial Screening

All studies were subject to pre-specified sifting criteria and filters. Articles were retained if they were (1) written in English; (2) published in a peer review

journal; (3) considered original research; (4) full text was accessible; (5) research was conducted in the UK.

1.3.4. Specific Inclusion Criteria

Following initial screening, the title and abstracts were subject to specific inclusion criteria (see table 1.2 below). Studies were included if they:

Primarily had a focus of religiosity or spirituality. Religiosity is complex and is generally viewed as a multi-dimensional construct (Khalaf *et al.,* 2014) and therefore is difficult to study in the role of mental health. There is recognition in the literature regarding the overlap of religiosity and spirituality (Curlin *et al.,* 2007a) with many different methods of measurement and definition. For purpose of this review, R/S were truncated to capture all variations and meanings. Studies were included regardless of their definition, if it was the primary focus of the study.

Also, participants of the studies were practicing mental health professionals within the UK. The search terms represented in Table 1.1. for mental health professionals, were chosen to reflect typical professional groups in the UK and professionals that patients may be in contact with, including those not always employed by the NHS (i.e. psychotherapists).

Finally, studies had a focus on an aspect of mental health practice or the impact/influence of religion/spirituality on practice. Consideration of how to define mental health practice was derived by typical explanations of professional's roles and how they are described in care (e.g. interventions are provided by therapists; treatments are provided by doctors; care plans are associated with patients). Data was extracted from a random selection of

studies to identify ‘practice’ terms and piloted with different variations. These were then cross-referenced with the other inclusion criteria to capture disparities.

Both qualitative and quantitative studies were included to capture differences in methods of examining the relationship between R/S and mental health practice; this included exploring attitudes toward R/S, and also the use, influence and impact of these concepts.

Variable	Include	Exclude
Relig* or Spiritual*	All definitions All belief systems / religions	None
Mental Health Professionals	Practicing UK mental health professionals (as described in section 1.3.4)	Students Researchers Other professionals (e.g. chaplains) patients
Mental Health Practice	All definitions (as described in section 1.3.4)	None
Population	UK-based research AND professionals	Any other countries
Study Design	Qualitative AND Quantitative	None
Relationship	All relationships between the 3 broad concepts	None

Table 1.2. Inclusion and Exclusion Criteria

1.3.5. Specific Exclusion Criteria

Studies were excluded if they: (1) did not focus on R/S; (2) research was not conducted in the UK; (3) did not have practising mental health professionals recognised in the UK mental health system (4) focussed on students due to the differences in training programmes.

1.3.6. Study Selection

As shown in the PRISMA flow diagram (figure 1.1), the search yielded 2743 citations, with 1375 after de-duplication and screening of titles. Thirty-two articles were left following screening of the abstracts using the specific inclusion and exclusion criteria. A further 4 studies were identified from the reference list of the articles. The full text of the remaining the 36 articles were reviewed and a further 18 articles excluded due to not having a primary focus on religiosity or spirituality (7) not being conducted in the UK (5) not primary/original research (4) and did not explore an aspect of mental health practice (2). This resulted in 18 studies being retained for quality assessment.

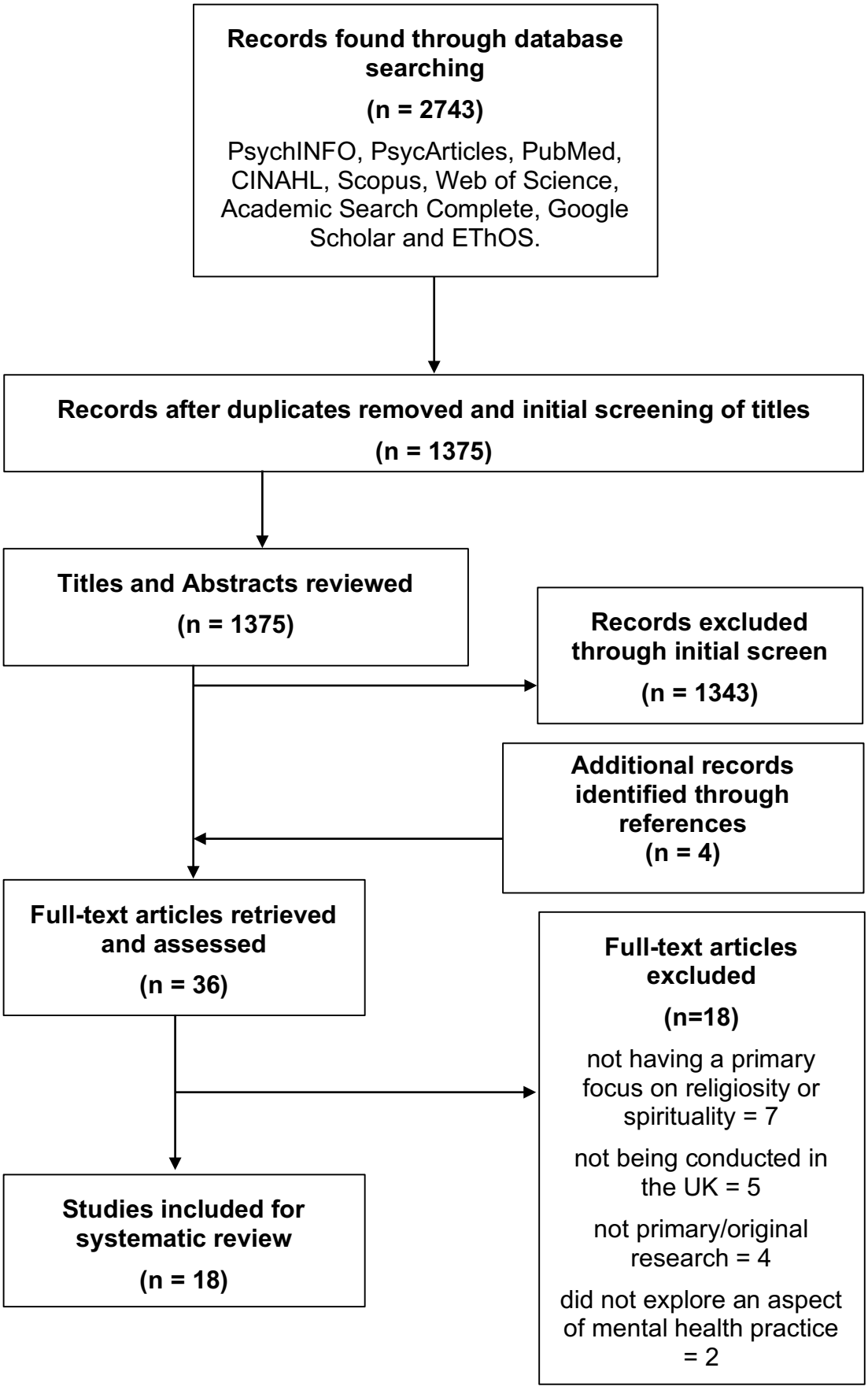


Figure 1.1. PRISMA flow-diagram of the literature search

1.3.7. Quality Assessment

To increase the validity and reliability of the systematic review and critique of the literature, a quality assessment of the 18 studies identified was carried out. A quality assessment framework (Caldwell, Henshaw & Taylor, 2011) was utilised in order to assess the quality of the 18 studies. This was considered a suitable tool for the current review as it is frequently used within health literature and professional training. Furthermore, the tool can be used to assess both qualitative and quantitative research.

All studies were scored against 13 quality criteria, with a further 6 quality criteria for quantitative papers and qualitative papers each. Studies were scored on each criterion with a 2 if the criterion was fully met, 1 if the criterion was partially met and 0 if the criterion was not met. The ratings were added up to give the study an overall score between 0 and 38 (see Appendix C); papers which scored a mid-point of 19 or below were independently re-reviewed for their level of satisfaction. A mid-point of 19 was selected as a cut-off as this may suggest the paper is not sufficiently comprehensive in outlining key areas which are considered essential to good quality research.

To enhance the reliability of the quality assessment further, a second researcher rated the articles independently against the same criterion and an inter-rater reliability analysis using the Kappa statistic was performed. The Kappa reliability coefficient for each paper is included in table 1.3 (below). It can be seen that no coefficient score was below k = 0.66 with an overall coefficient reliability value of k = 0.89 which represents a strong pattern of inter-rater reliability.

One paper failed to meet mid-point for quality assessment by both researchers and was excluded from the review (k =.84). The quality assessment also highlighted one study's (Martinez & Baker, 2000) relatively poor quality with an overall score of 19. The study did not sufficiently justify the rationale or the methodology used and had limited discussion. However, it must be noted that this paper was a short paper, presenting only a summary of results of an unpublished doctoral thesis, which was not retrievable during the time of the review. The quality assessment for the 18 articles ranged from 15 – 35, with 14 papers scoring between 25-35.

1.3.8. Characteristics of Studies

A summary of the key characteristics of the final 17 studies can be found in Table 1.3. below. Fifteen studies used a qualitative approach; five using interpretative phenomenological analysis; four using a grounded theory approach; one using discursive; one using Heideggerian; one using thematic analysis; one unspecified; one a mixed 2-wave qualitative approach. Two studies used a quantitative approach (cross-sectional) and one a mixed method (cross-sectional quantitative survey with qualitative analysis of feedback). All qualitative papers used semi-structured interviews or topic guides. Both quantitative papers used an anonymous survey methodology.

Fourteen of the studies focussed on single professional groups (Clinical Psychologists [2]; Psychiatrists [2]; Nurses [1]; Occupational Therapist [1]; Therapists [8]). The remaining studies had a mix of professional groups. For the qualitative studies, sample size ranged from 3 – 30. All studies attempted to use a mix of genders. Of note, only 3 papers discussed the difficulty of defining religiosity or spirituality as part of their rationale.

1.3.9. Analysis

As illustrated by the study characteristics, the majority of studies included were qualitative in nature. Qualitative research is often not generalisable (Thomas & Harden, 2008), thus it is often difficult to systematically review. Reviewers are often at risk of de-contextualising the findings. In order to reduce the risk of de-contextualisation, increase validity and to answer the research aims, a thematic synthesis approach as described by Thomas and Harden (2008) was adopted in analysing and interpreting the data.

Stage 1 and 2 involved coding the text presented in the primary research papers included in this review. Thomas and Harden (2008) suggest this be done line by line, however, it was felt that with qualitative papers largely providing summaries or examples of data, this was not suitable. Data was coded with several descriptors based on each finding presented in the paper. Descriptive subjects close to the original results were identified; themes were then derived and developed from these subjects. Transitional concepts were identified to group these themes and identify any emerging patterns between primary papers. All the coded text was then examined to check for consistency of interpretation (similar to 'axial' coding in grounded theory). This process created a total of 14 descriptive themes.

A draft summary of the findings across the studies organised by the 14 descriptive themes was written by the lead author. A research assistant then commented on these findings.

Stage 3 involved generating analytical themes beyond the original findings of the primary research (similar to 'third order interpretations' in meta-ethnography). Nine analytical themes were identified in line with the research

aims. This was then reviewed by the lead author and research assistant and 3 super-ordinate themes were agreed.

The primary research studies results are used to create a narrative to describe each theme. In doing this, it is hoped that the results of this review are presented whilst also demonstrating the findings of the primary research papers.

Author(s)	Year	Study Aim	Research Design	Sample Population	Method of Data Collection	Key Findings	Quality Rating
Baker & Wang	2004	How the intersection of workplace experience and religious values enhance/detract from practice	Qualitative - Grounded Theory	14 Christian Clinical Psychologists (11 Female, 3 Male). All employed by the NHS (7 FT, 7 PT) across various services.	2 Stage - 1) Repertory Grid - to identify 'Constructs and Elements' (2) Semi-structured Interviews subject to Grounded Theory	Three theme: (1) Added dimension to work; (2) disclosure to colleagues and clients; (3) values congruence/clash of integration	27 (K = .91)
Blair	2015	Explore the influence of therapist spirituality on practice	Qualitative - Grounded Theory	9 Therapists (3 Counselling Psych; 3 Psychotherapists; 3 Counsellors)	Semi-structured interviews (3 by phone and 6 face-to-face)	One major theme: the processes involved in integrating spirituality into practice. Two sub-themes (1) influence of spirituality on therapeutic work and (2) harmony between spirituality and professional context	32 (K = .88)
Crossley & Salter	2005	How clinical psychologists address spirituality in therapy and professionals understand and attitude toward it.	Qualitative - Grounded Theory	8 Clinical Psychologists (4 male, 4 female). All worked in the NHS across various services.	Semi-structured interviews (3 by phone and 6 face-to-face)	Two core themes: (1) spirituality as elusive and (2) finding harmony with spiritual beliefs	32 (K = .87)

Dura-Vila, Hagger, Dein & Leavey	2011	Explore Attitudes and beliefs toward religion / spirituality and its implications for practice (therapeutic relationship, management and care) and differences between migrant psychiatrists and UK psychiatrists	Qualitative	20 Psychiatrists (11 female, 9 male); Range of grades and various areas. 9 English and 11 migrant psychiatrists.	Semi-structured interviews. Topics derived from a pilot interview with 3 participants.	Three main findings: (1) Migrant psychiatrists views of dissonance between home countries and UK (where patients religious beliefs are not incorporated and standard). (2) Positive attitude amongst UK psychiatrists. (3) Need for training.	26 (K = .82)
Eeles, Lowe & Wellman	2003	Identify what features Mental Health Nurses consider significant in the assessment of spiritual experiences. Explore how these are used in judgements. Whether personal beliefs affected this.	Qualitative - Thematic Analysis	14 Mental Health nurses (13 Registers and 1 trainee). 7 female and 7 male.	3 Stage: (1) Gaging Attitudes (2) Vignettes (3) Specific areas which affect evaluation. All three stages used a questionnaire to guide the discussion. Questionnaire derived from pilot.	Complex criteria are used to evaluate spiritual experiences. Outcome of the experience is a major factor. Personal and cultural context is also a major contributing factor. Nurses do not rely on feature identification only. Nurses personal beliefs can impact evaluations.	31 (K = 1)

Foskett, Marriott & Wilson-Rudd	2004	Evaluate a service for religious and spiritual needs and its impact on professionals and communities. To examine professionals views on spirituality and mental health. Utilisation of the chaplaincy.	Quantitative – Cross-Sectional	89 Completed questionnaires for Professionals (6 Psychiatrists, 30 nurses, 17 assistants, 6 managers, 5 social workers, 3 Psychologists, 7 OT) and 68 for religious leaders (All Christian)	Questionnaires (Derived from Neeleman & King, 1993).	Majority of participants recognised link between religion and mental health. Religious leaders felt mental health could impact religious beliefs. Majority of professionals asked about religious beliefs. Majority of professionals would not talk about their own beliefs. More than half of professionals would refer or suggest speaking to religious leaders. Majority of professionals have received inadequate training, but would welcome it.	25 (K = .91)
Gubi	2004	To gain an overview of the use of prayer in mainstream counselling.	Mixed (Quantitative and Qualitative [IPA])	247 BACP Counsellors and 96 CMCS counsellors	Questionnaires - derived from small scale project	Prayer is widely accepted by mainstream counsellors and more half have used it before sessions and for patients. A quarter have discussed it in supervision. Four main these identified (Philosophical Overview; Covert Prayer; Overt Prayer; Ethical Practice)	20 (K = .93)
Gubi	2009	Whether counsellors are aware of the ethical problems of using prayer. What the	Qualitative - IPA	19 Counsellors (14 BACP; 5 CMCS)	Interview	Counsellors are aware of the ethical problems. A number of challenges including the way counsellors are perceived, power dynamics, ethical intervention.	26 (K = 1)

		potential problems of using prayer are.					
Jackson & Coyle	2009	Explore therapists responses when there is a difference in spiritual stance between client and counsellor. Exploring the dilemma, ethical implications and strategies.	Qualitative - IPA	11 Therapists (3 Counselling Psychologists, 1 Clinical Psychologist, 5 Psychotherapists, 2 Counsellors). Majority worked in the NHS.	Semi-structured interviews	Three main themes (1) perception of clients spiritual beliefs (2) aims and responsibilities (3) responses to unhelpful spiritual beliefs. Conflict between respecting beliefs and enhancing well-being.	35 (K = .78)
Martinez & Baker	2000	Explore the interplay of religiosity and professional practice in psychodynamic counsellors	Qualitative - Grounded Theory	8 Psychodynamic counsellors (6 women, 2 men). 4 Private practice and 4 third sector. All Christian.	Semi-structured interviews	Three main themes (1) changes in religiosity (2) issues of self-disclosure of religion (3) issues in training.	19 (K = 1)
McViittie & Tiliopoulos	2007	How psychotherapists describe practice with religious clients and how these descriptions give weight within the therapeutic process.	Qualitative - Discursive	6 Psychotherapists (3 male, 3 female).5 Clinical Psychologists and one Psychiatrists. 3 in the NHS and 3 in private practice.	Semi-structured interviews	Therapists consider religious beliefs as important but only relevant to certain clients. Therapists can reconstruct religious beliefs to work with practice.	29 (K = .80)

Mir, Meer, Cottrell, McMillan, House & Kanter	2015	Develop faith-sensitive adaptation of BA. Test the feasibility and acceptability. Without compromising the core mechanisms of BA.	Mixed Methods Qualitative - 2 wave study exploring development of faith adapted model.	Study 1: 29 informants (22 local, 7 national) - 9 Mental Health Workers, 6 BA therapy academics, 5 Clinical Psychologists, 4 Muslim service users, 3 Managers, 2 GPs Study 2: 3 Therapists and 19 patients for intervention (13 interviewed for the study).	Study 1: Interviews following a topic guide to identify themes and develop a model. Study 2: Two researchers checked adherence by rating recordings. Interviews with Patients and staff.	Study 1: Four main themes: (1) Relevance of the model (2) social context (3) patient-therapist matching (4) religion and therapy. Study 2: Model was found acceptable to patients. Therapists needed more support	32 (K = .88)

Neeleman & King	1993	If personal religious beliefs and attitudes of psychiatrists influence opinions about the link between mental health and religion or clinical practice.	Quantitative – Cross-Sectional	231 Psychiatrists	semi-structured questionnaire (multiple choice with space for feedback)	27% reported religious affiliation and 23% belief in God. 92% felt psychiatrists should concern themselves with religious issues of patients. Psychiatrists who were religious more likely to refer to religious leaders or disclose their faith. Psychiatrists beliefs did not have an influence on their practice.	30 (K = .76)
Udell & Chandler	2000	Add to the conceptualisation of spirituality by understanding OT's experiences. Understand problems around spirituality in practice for OT's. Explore Christian OT's experience and practice.	Qualitative - IPA	3 Christian OT's	Semi-structured interviews	Difficulty defining spirituality but able to recognise clients spiritual needs. Recognition that their role did not include spiritual counselling, but involve recognising clients spiritual needs.	28 (K = 1)
West	1997	Explore experiences of counsellors who use healing and how this could be understood within theory.	Qualitative - IPA	30 people interviewed (27 returned follow-up questionnaires). Mostly private practice.	Two phase approach. (1) interview. (2) human inquiry group over 4 weekends.	Main themes: (1) transition toward healing (2) taboo of spirituality and healing (3) nature of healing distinct from therapy (4) supervision difficulties (5) spiritual space.	31 (K = .78)

West	1998	Impact of Quaker beliefs on practice.	Qualitative - IPA	18 Quaker therapists (16 women, 2 men). 13 Counsellors, 6 psychotherapists (one participant pulled out).	Semi-structured interviews	Spiritual beliefs helped therapists understand client's spiritual journey's better and it underpinned their work. Therapists reported spirituality provided inspiration, preparation. Conflict in supervision and secular settings was also noted.	32 (K = .66)
Wyatt	2002	How psychodynamic counsellors respond in themselves and with clients when discussion religion	Qualitative - Heideggerian phenomenological research	5 therapists (3 men, 2 women)	semi-structured interviews	Themes include: (1) counter-transference within therapy (2) external responses (3) the working context (4) religion within the client/therapist relationship	30 (K = .78)

Table 1.3. Characteristics of Studies

1.4. Results

From the 17 studies reviewed, the principal issue found related to the barriers that prevented professionals from engaging with R/S in clinical practice. These barriers can be organised around 3 central themes. The first theme explores the corporate context (i.e. lack of engagement with R/S within the structures of the NHS and governing professional organisations). The second explores ethical considerations and dilemmas of how to work with R/S in clinical practice. Finally, the third theme explores issues in daily practice including professionals' attitudes, practices and engagement. These themes were ordered to represent the hierarchal nature in which professionals practice (i.e. moving from the macro- to the micro- level).

1.4.1. Corporate Context

Given the complex nature of R/S, the studies in this review have highlighted several contextual issues specifically related to structures and bodies in which professionals practice and how these impact and influence professionals' ability to engage with R/S issues in practice.

1.4.1.1. Corporate Issues

Corporate issues refer to barriers experienced within the wider health community, specifically the role of professional bodies and approaches used by professionals. Only one study directly commented on the engagement of R/S at a corporate level; Dura-Vila *et al.,* (2011) found that migrant psychiatrists feared judgement from the British medical community for discussing R/S with clients or colleagues. They also found that psychiatrists (UK and non-UK born) felt there was a lack of support from the medical

community and GMC. Furthermore, migrant psychiatrists would frequently incorporate R/S into mental health care in their home countries, but not in the UK, suggesting that it is a taboo subject within the UK system. Crossley and Salter (2005) specifically highlighted comments suggesting that R/S is not a topic that Clinical Psychologists engage with, inferring that it may be a wider professional issue rather than down to the individual clinician.

Foskett *et al.* (2004) study was conducted across one local NHS Trust, which could suggest an acceptance and recognition of R/S at a corporate level. They also found that 2/3 of professionals supported the notion of the NHS employing religious leaders, implying that the NHS should do more in providing space for R/S issues within health care. This is supported by Neeleman and King (1993) who found that 59% of professionals feel the NHS should employ religious leaders. Neither study specifically reported or commented on how many religious leaders were employed by the NHS or what service provisions were in place. It is worth noting that the study by Neeleman and King (1993) was the only study which was felt to fully meet the criteria for generalisability; Foskett *et al.* (2004) only partially met this criterion due to the specific nature of the research (exploring views for services within a specific NHS Trust).

Only 1 study discussed barriers in terms of professional approaches. Mir *et al.,* (2015) who developed a faith adapted intervention for Muslim's, highlighted the need for therapeutic approaches to be adapted to incorporate R/S issues. They also found that professionals wanted more guidelines and advice on how to work with R/S issues within the therapeutic approach. Conversely, Udell and Chandler (2000) argue that professional guidelines on working with R/S may not be helpful as it is a very personal and private topic to individuals. Although

not directly discussed, the three papers which examined psychodynamic therapists (Blair, 2015; Martinez & Baker, 2000; Wyatt, 2002), found that professionals frequently state disclosure goes against their training; this could be suggestive of the lack of engagement with R/S issues specifically from this therapeutic approach and more externally the psychodynamic community.

1.4.1.2. Training

Seven studies specifically cited lack of training as a barrier to engagement (Blair, 2015; Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; Martinez & Baker, 2000; McVittie & Tiliopoulos, 2007; Mir *et al.,* 2015; Neeleman & King, 1993). It was felt that there was still an attitude of disdain toward R/S issues in professional training (Blair, 2015) and was often not even discussed (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; Foskett *et al.,* 2004; Martinez & Baker, 2000; Mir *et al.,* 2015). It was suggested that training fails to adequately prepare professionals to work with R/S issues (Mir *et al.,* 2015)

Martinez and Baker (2000) found that religious professionals experienced a change in their faith through training, with faith no longer being the 'governing force' in their life. This was not found to be a negative view, with professionals reporting it was simply maturation of the self. Similarly, Blair (2015) found that despite training posing challenges to R/S of professionals, it could, in fact, be positive and help professionals with growth. This could be suggestive that R/S is addressed within the individual during training (i.e. personal development), but not in relation to practice.

Six studies reported that professionals would welcome and value further training (Blair, 2015; Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; McVittie & Tiliopoulos, 2007; Mir *et al.,* 2015; Neeleman & King, 1993). Blair (2015)

found that professionals who had received training on R/S found it beneficial and it helped bridge the gap and create harmony with practice.

1.4.1.3. Supervision/Management

Seven studies found that professionals did not feel supported by supervisors in dealing with patient's R/S needs (Dura-Vila *et al.,* 2011; Gubi, 2004; Gubi, 2009; Martinez & Baker, 2000; Mir *et al.,* 2015; West, 1997; West, 1998). Martinez and Baker (2004) suggest it may be that supervisors simply do not understand the issues for either the professional or the patient. Supervisors may have the same difficulty engaging with R/S that their supervisees bring. Dura-Vila *et al.,* (2011) also found that psychiatrists felt a lack of support and fear from teams and managers in discussion R/S issues.

In the 3 studies which explored specific R/S interventions (e.g. prayer, healing) (Gubi, 2004; West, 1997; West, 1998), professionals reported experiencing conflict and were reluctant to share information with supervisors. Gubi (2004) specifically reported that, of the 59% of BACP counsellors who used prayer in their work, 60% of these did not discuss it in supervision and only 24% of those who had used overt prayer had discussed this in supervision. No explanations for this were provided within these papers. Of note, the paper by Gubi (2004) scored poorly on quality assessment (overall 20), with the methodology and qualitative elements in particular scoring low.

1.4.2. Ethical Considerations

Two particular barriers highlighted by the primary research papers was that of ethical dilemmas professionals face in engaging with R/S in practice and dilemmas religious professionals face.

1.4.2.1. Dilemmas

A significant barrier to engagement was the ethical dilemma between respecting patients' beliefs versus helping them overcome distress. Four studies found that professionals struggle to work with R/S when it was viewed as contributing to the patient's distress (Crossley & Salter, 2005; Gubi, 2009; Jackson & Coyle, 2009; Mir *et al.,* 2015). Jackson & Coyle (2009) suggested it is the responsibility of the patient to want to change and work toward their goal and that giving patients the power to change beliefs is more ethical. Professionals viewed well-being as an internal desire, whereas respecting beliefs was seen to be externally imposed, however, this would override any internal desire based on the patient's wishes (Jackson & Coyle, 2009).

A second key dilemma was that of patient-therapist matching (Dura-Vila *et al.,* 2011; Eeles *et al,* 2003; Mir *et al.,* 2015). There appear to be mixed views regarding this. Three authors reported professionals see the benefits, as there would be a shared value base and patients may not have to explain certain metaphors of specific beliefs (Eeles *et al.,* 2003; Dura-Vila *et al.,* 2011; Mir *et al.,* 2015). However, Mir *et al.,* (2015) also found that patients may not wish to see professionals from the same or similar background out of fear of being judged and confidentiality. They also highlighted that patients may not wish to discuss R/S in mental health care and therefore the authors reported that the use of the values tool helped in identifying if patients wanted to discuss R/S issues, which may aid in overcoming this dilemma.

Finally, the last dilemma and ethical issue found was that of the use of R/S interventions within practice. West (1998) reported that 73% of therapists prayed for clients. Gubi (2004) reported that 59% of BACP counsellors used

covert prayer in their work and 17% have used overt prayer. Both authors noted that professionals found it supportive and helpful for the preparation of sessions, guidance and as an internal supervisor. Gubi (2009) suggested that using prayer within therapeutic work may alter the 'power dynamic' and the way in which a professional is perceived. Gubi (2009) also notes that professionals must be accountable for the interventions they use and be able to justify them. Interestingly all three papers (Gubi, 2004; Gubi, 2009; West, 1998) report that professionals are hesitant to discuss the use of prayer within supervision.

Although West (1997) explored the use of healing, the author did not comment on the ethics of this within practice. Mir *et al.,* (2015) commented that R/S patients may wish to use alternative methods and professionals' must accept the use of healers alongside mainstream care. However, this does not imply that mental health professionals should use methods beyond the scope of their professional competency and accepted practice.

1.4.2.2. Religious Professionals

A particularly important ethical consideration was R/S of professionals and how they engage with R/S within practice. Neeleman and King (1993) found that approximately 75% of psychiatrists report no religious affiliation, however, that 70% attend a religious service at Christmas. They also found higher levels of religious affiliation amongst migrant psychiatrists (35%). No other studies reported levels of R/S within professionals, however, all the studies had at least some religious or spiritual participants. West (1998) found that 72% of therapists reported that faith underpins their work. Interestingly, Neeleman and King (1993) found, despite 75% reporting no religious affiliation, only 33% of

their parents reported no religious affiliation. Two studies found that faith was the primary factor in entering the profession (Martinez & Baker, 2000; West, 1998).

Several studies highlight benefits of R/S toward professionals, specifically in that R/S can help professionals cope with difficulties in both personal and professional life (Baker & Wang, 2004; Blair, 2015; Dura-Vila *et al.,* 2011; Eeles *et al.,* 2003; Gubi, 2004; Martinez & Baker, 2000; Udell & Chandler, 2000; West, 1998). Furthermore, that R/S improved professional's ability to work with patients (Blair, 2015; Dura-Villa *et al.,* 2011; Eeles *et al.,* 2003) as personal religious beliefs help with being more open to client's spiritual journeys (Udell & Chandler, 2000; West, 1998). One study also found that professionals viewed working with patients' spirituality as enhancing understanding of their own spirituality (Blair, 2015). R/S was also viewed as enhancing therapeutic practice by allowing the professionals to be more empathetic/compassionate (Blair, 2015; Dura-Vila *et al.,* 2011).

Some specific reflections were also highlighted; Gubi (2004) found professionals use prayer as an internal supervisor as it is a process that creates space for reflection and allows for communication between the inner world experiences and unconscious processes. Baker and Wang (2004) also reported that professionals felt there is a similarity between religion and psychology, where both promote a non-judgemental ethos; and that there is no conflict between faith and therapy (West, 1998). Blair (2015) found that spirituality has a place in professional identity and that it can help with a synthesis of the self. Lastly that R/S beliefs allow professionals to be more

open to R/S issues of clients (Dura-Vila, *et al.,* 2011; Eeles, *et al.,* 2003; Martinez & Baker, 2000; Udell & Chandler, 2000; West, 1998).

1.4.2.3. Self-Disclosure/Imposing Views

A key issue emphasised by all the studies was the importance of professionals not imposing their views on patients. This was particularly important if professionals had limited knowledge of patients' beliefs or negative personal experiences which may influence their behaviour (Crossley & Salter, 2005).

A significant concern highlighted by professionals was the conflict of self-disclosure (Baker & Wang, 2004; Blair, 2015; Foskett *et al.,* 2004; Martinez & Baker, 2000; Neeleman & King, 1993). These studies reported divided views regarding professional's disclosure their own R/S beliefs. Only 15%-18% of professionals had readily disclosed their own faith (Foskett *et al.,* 2004; Neeleman & King, 1993). Two core conflicts appear to influence self-disclosure, that of disclosure from the perspective of professional training/bodies and beliefs from a religious perspective. Martinez and Baker (2000) found that psychodynamic therapists were against disclosure, in line with their training. This may also extend out to general professional views that professionals R/S beliefs should be kept private (Dura-Vila *et al.,* 2011; Foskett *et al.,* 2004). Baker and Wang (2004) found that Christians particularly found this conflict difficult as traditionally Christians are open about their faith.

Generally, the consensus appears to be that professionals would disclose their R/S beliefs if specifically asked and it was helpful to the patient to know (Baker & Wang, 2004; Blair, 2015; Dura-Vila *et al.,* 2011; Foskett *et al.,* 2004; Martinez & Baker, 2000; Neeleman & King, 1993).

1.4.3. Daily Practice

This final theme explores barriers to professionals' engagement with R/S in clinical practice. A number of significant issues have been highlighted, particularly that of defining R/S, attitudes of professionals, and working with R/S issues.

1.4.3.1. Engagement

Six studies have reported unease, discomfort, anxiety and sensitivity on the part of professionals as key reasons for failing to engage with R/S within practice (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; McVittie & Tiliopoulos, 2007; Mir *et al.,* 2015; Neeleman & King, 1993; Wyatt, 2002). Several possibilities have been given for this, including a lack of knowledge regarding faith, how to approach it and paucity of language available (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; Mir *et al.,* 2015; Wyatt, 2002), lack of training (Blair, 2015; Crossley & Salter, 2005; Dura-Vila *et al.,* 2011) and lack of support (Dura-Vila *et al.,* 2011; Mir *et al.,* 2015).

Five studies reported that majority of professionals do not routinely ask patients about R/S unless the client brings it up themselves (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; McVittie & Tiliopoulos, 2007; Mir *et al.,* 2015). Contrary to this, two studies found that 93-97% of professionals ask about R/S issues (Foskett *et al.,* 2004; Neeleman & King, 1993). Two studies argued that therapists do work with R/S issues within practice by re-formulating client's R/S beliefs into more familiar terms such as thinking patterns and internal working models (Jackson & Coyle, 2009; McVittie & Tiliopoulos, 2007); suggesting that therapists are always working with a client's belief system, so indirectly work with R/S within this (McVittie & Tiliopoulos, 2007). They also highlighted some

unorthodox views such as religious beliefs not being part of psychology and that beliefs become a response to intransigence rather than failure of the therapist.

Dura-Vila *et al.,* (2011) reported psychiatrists' views that incorporating beliefs into practice would improve engagement and satisfaction with services. There appeared to be a generally positive view of incorporating R/S into practice indirectly through the use of religious leaders (Crossley & Salter, 2005); 53% - 57% of professionals felt that the NHS should fund religious leaders (Foskett *et al.,* 2004; Neeleman & King, 1993). Nevertheless, the majority of professionals (58% - 61%) had never made a referral to a religious leader or chaplain. Similar results were found when religious leaders were asked about referring to mental health professionals (Foskett *et al.,* 2004) with the majority (60%) of religious leaders referring to GPs and only 30% to a mental health professional.

1.4.3.2. Attitudes toward Religiosity/Spirituality

Several studies found that professionals viewed R/S as significantly linked to mental health (positively or negatively) (Dura-Vila *et al.,* 2011; Eeles *et al.,* 2003; Foskett *et al.,* 2004; Neeleman & King, 1993) with 2 studies identifying 83% - 92% of professionals considering it important in mental health (Foskett *et al.,* 2004; Neeleman & King, 1993). Dura-Vila *et al.,* (2011) found both UK born and migrant psychiatrists felt it was an essential part of psychiatric care and should be part of management plans.

It was frequently commented that professionals need to be aware of their own attitudes regarding R/S prior to engaging with this in practice (Dura-Vila *et al.,* 2011; Jackson & Coyle, 2009; Mir *et al.,* 2015; Udell & Chandler, 2000),

especially as these views and attitudes (positive or negative) may 'leak out' (Blair, 2015). Two studies commented that working with R/S in practice was more difficult when working with clients who were fundamentalist or dogmatic (Blair, 2015; West, 1998) and that therapists expressed concerns over coming across patronising and preaching (Mir *et al.,* 2015).

Seven studies established that professionals' attitudes toward R/S were generally positive (Dura-Vila *et al.,* 2011; Eeles *et al.,* 2003; Foskett *et al.,* 2004; Neeleman & King, 1993; Udell & Chandler, 2000; Wyatt, 2002). Neeleman and King (1993) found that 61% of psychiatrists felt that religion had a protective influence against mental health. Two studies reported the view that R/S can be specifically helpful in aiding recovery and improving functioning (Dura-Vila *et al.,* 201; Eeles *et al.,* 2003) by providing patients with coping skills, social support, a safe place, optimism and hope (Dura-Vila *et al.,* 2011; Wyatt, 2002). Foskett *et al.* (2004) noted that 88% of professionals would refer a patient to a religious leader if asked; with a general consensus amongst studies that R/S should be incorporated into practice and care (Baker & Wang, 2004; Blair, 2015; Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; Eeles *et al.,* 2003; Foskett *et al.,* 2004; Gubi, 2009; Mir *et al.,* 2015; Neeleman & King, 1993; Udell & Chandler, 2000).

Interestingly, Neeleman and King (1993) highlighted an inverse relationship whereby 52% of psychiatrists felt that mental health would reduce religiosity/religious beliefs, especially amongst doctors who believed in God (64% vs 48%); with 78% of psychiatrists considering religion as a way to sublimate psychological problems and 42% believing that it may in fact lead to mental health problems. Foskett *et al.* (2004) found similar views, with 66% of

religious leaders suggesting that mental health could confuse people about their religion and that religion can lead people to mental health problems. They also report that 40% of mental health professionals believe that mental health could reduce religious beliefs and 45% that religion could lead to mental health. There also appears to be more of a negative attitude within psychodynamic orientations where R/S is often viewed as a defence or way of not having to feel (Blair, 2015; Martinez & Baker, 2000; Wyatt, 2002).

1.4.3.3. Defining Religiosity/Spritiuality

It was generally acknowledged in most studies that R/S are difficult concepts to describe (Crossley & Salter, 2005; Dura-Vila *et al,* 2011; Eeles *et al.,* 2003; Jackson & Coyle, 2005; Udell & Chandler, 2000; West 1997). Spirituality commonly was described as more complex with several overlapping meanings (Crossley & Salter, 2005; Udell & Chandler, 2000; West, 1997); which included aspects of connectedness (Crossley & Salter, 2005; Udell & Chandler, 2000; West, 1997) and being more than conventional religious affiliation (Blair, 2015; Udell & Chandler, 2000; West, 1997). It was also found that professionals struggle to grasp the fundamental concept of R/S (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011) and therefore avoided these topics.

Of the 17 papers, none used a specific definition within their rationale and no firm conclusion was drawn as to the definition. Crossley and Salter (2005) commented that definitions need boundaries, whereas Gubi (2004) used a very broad definition of prayer which allowed professionals to use their own meaning/understanding. McVittie and Tiliopoulos (2007) also found professionals would often re-frame R/S into psychological terms and religious beliefs were re-formulated into spiritual beliefs therefore completely removed

from consideration. None of the papers directly addressed the definition of religion or religiosity, citing it as a very sensitive topic (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; Mir *et al.,* 2015).

1.4.3.4. How to Work with Religiosity/Spirituality in Practice

A fundamental conclusion of the literature when working with R/S within practice was the need to respect patients' beliefs (Blair, 2015; Crossley & Salter, 2005; Dura-Vila *et al.,* 2011; Eeles *et al.,* 2003; Gubi, 2004; Jackson & Coyle, 2009; Mir *et al.,* 2015; Udell & Chandler, 2000; West, 1998; Wyatt, 2002). There were mixed views as to whether patients should be asked about R/S or it was better to wait for them to broach the subject (Crossley & Salter, 2005; Dura-Vila *et al.,* 2011). Foskett *et al.* (2004) found that 83% mental health professionals thought it was important during assessment, however, this reduced to 39% during treatment. Interestingly, they found that religious leaders believed the opposite with 31% considering it important during assessment, and 65% during treatment.

Eeles *et al.,* (2003) study provided some useful insights regarding how to assess R/S experiences given the ambiguity over the relationship between R/S and mental health. Specifically, they found that nurses consider the nature of the experience, outcome, functioning, frequency, duration, context, behaviours, indicative of whether spiritual experiences were psychopathological in nature or not. However, a key issue highlighted by several authors was the hesitancy of professionals to challenge patients' spiritual beliefs (Crossley & Salter, 2005; Gubi, 2004; Gubi, 2009; Jackson & Coyle, 2009; Mir *et al.,* 2015). Furthermore, Eeles *et al.,* (2003) study specifically focused on psychopathology, whereas many professionals find

issues of R/S difficult as topics, rather than experiences explicitly. Instead, Mir *et al.* (2015) found that the values tool was helpful in aiding professionals to understand how important R/S was to a patient and whether to incorporate it into practice.

Crossley & Salter (2005) suggested that professionals need to understand the meaning of R/S to the patient and how these impact on their life by adopting an empathetic approach. Professionals accepting that difficulties may have different meanings and R/S may address these, was felt an important factor by several authors (Crossley & Salter, 2005; Gubi, 2009; Jackson & Coyle, 2009, Mir *et al.,* 2015; Wyatt, 2002). Wyatt (2002) specifically found that religious language could be symbolic and offer insights into patients' object relations; the therapeutic relationship could be a means to explore this, as well as for change with both relationships to R/S beliefs and psychological well-being (Jackson & Coyle, 2009). If the professional felt comfortable in doing so, Mir *et al.,* (2015) suggested that therapeutic goals could be presented through the framework of religious teachings; and where possible support patients to explore positive interpretations of religious teachings to challenge depression. However, this could be seen to be beyond the role of a therapist and create further ethical issues. Instead, Jackson and Coyle (2009) suggested that therapists should encourage patients to weigh and consider whether spiritual beliefs were helpful and to use R/S teachings to examine how closely their current beliefs aligned with other religious beliefs. Mir *et al.,* (2015) demonstrate good validity for the use of a manualised faith-adapted approach would enable less religious professionals to work with religious patients.

Finally, several authors have commented on the use of professionals' own R/S beliefs as a method to work with patients (Blair, 2015; Crossley & Salter, 2005; Eeles *et al.,* 2003; Gubi, 2004; Gubi, 2009; Jackson & Coyle, 2009; Mir *et al,* 2015; Wyatt, 2002). Some authors have even suggested patients and professionals should be matched based on backgrounds to facilitate understanding and shared values (Dura-Vila *et al,* 2011; Mir *et al.,* 2015). There are numerous ethical dilemmas which arise with this such as the imposition of views and accountability of interventions. Additionally, it was highlighted that this requires professionals to have self-knowledge and be able to reflect on spirituality and its place in professional identity (Blair, 2015).

1.5. Discussion

The aim of this review was to examine and understand the literature regarding how professionals engage with R/S during clinical practice. In keeping with the wider literature, there appears to be a very complex picture regarding R/S and mental health.

Broadly, it is clear that mental health professionals accept that there is a link between R/S and mental health. The direction of the relationship appears to cause many difficulties for professionals due to the complexity which is also apparent in the wider literature (Koenig, 2007) and was not specifically examined in this review. Multiple studies and reviews have attempted to explore and summarise the relationship (Dein, 2006; Koenig, 2007). However, a key issue highlighted within this review was the lack of clarity in how professionals engage with R/S, regardless of the relationship. As such, the analysis instead found that barriers to engagement were more pertinent when

considering R/S in clinical practice. These barriers extend to both the macro- and micro-level of practice.

This discussion will explore the significance and implications of the main findings and how these might be addressed.

1.5.1. Significance and Implications of Main Findings

At the macro-level it can be seen that the literature does not directly address corporate issues to engagement with R/S in the NHS or professional bodies; the implication being that professional bodies do not engage with R/S issues. With the complexity of R/S clearly within the literature (Koenig, 2007), it is surprising why guidelines are not specifically mentioned in the research. Dura-Vila *et al.,* (2011) highlighted migrant Psychiatrists views, that the medical community would be disapproving of incorporating R/S within practice, yet this did not appear to be the case. It may be that misconceptions such as this fuel ambivalence to engage with R/S.

NICE guidelines in the UK state that when considering treatments, professionals should consider patients' beliefs (Burford, Worrow & Caspary, 2009); however, this could be considered very vague. The majority of professional guidelines from various professional bodies, also have an aspect of understanding or respecting a patient's beliefs (Puchalski, 2001). It is also clear from this review that the majority of professionals consider R/S as an important aspect of mental health and that it should be incorporated. The fundamental difficulty appears to be due to a lack of consensus on how this should be done. Differing aims and values of professional groups may be an influencing factor within this. It is often cited that nurses more fully incorporate R/S within care, seeing it as a fundamental part of the person and within the

remit of their role (Fawcett, 2004); whereas GPs and Psychiatrists may have more of a focus on recovery through medical methods as per their training (Rao, 2005).

Like the NIMHE project for Spirituality and Mental Health, there needs to be a commitment from mental health professional bodies to incorporate R/S into guidelines in a more concrete way. Without this, the impact on daily practice and professionals' ability to engage with R/S is substantial and can clearly be seen in the findings of this review.

In particular, some of the ethical considerations and dilemmas highlighted could be avoided with more guidance; for example, the concern of many professionals in knowing how to challenge patient's R/S beliefs when it was viewed as causing distress. Also, guidelines and clearer working practices including manualised approaches for R/S have shown to be beneficial in alleviating discomfort for professionals (Mir *et al.,* 2015). This has also been found in other countries were faith-adapted approaches have been more widely developed and accepted (Anderson *et al.,* 2015). Although, it could be argued that professionals should have the core skills in knowing how to respect patient's beliefs whilst working with distress (McViittie & Tiliopoulos, 2007).

It may be that manualised approaches would give more structure and accountability to interventions and possibly facilitate better support from supervisors and managers. This may also eliminate ethical dilemmas surrounding the use of interventions such as prayer without patient's consent. Furthermore, mental health care in the UK draws upon evidence-based practice (Gubi, 2009), it may be easier to develop a strong evidence base for incorporating R/S into clinical practice through manualised approaches.

Given some of the findings suggesting high numbers of counsellors using interventions such as prayer, professionals discomfort of working with R/S issues, and professionals not discussing R/S within supervision, it would be beneficial for services to understand some of the barriers. Service evaluations and research would give a good insight into how professionals are engaging with this in practice as well as highlighting any ethical issues and testing the boundaries of practice. Again, this requires engagement at a macro-level by professional bodies and sufficient corporate structures to support this.

This review has also highlighted a particular issue in training of professionals in relation to R/S, which is in keeping with the wider literature (Bhugra, 2016). However, unlike some other comparable countries in Continental Europe, USA and Canada, the UK does not have training programmes which are religiously or spiritually oriented; except in counselling which has many different governing organisations such as the Churches' Ministerial Counselling Service (CMCS). Furthermore, the UK is largely seen as a secular state, therefore it may be unsurprising there is less engagement by professional bodies. Regardless, given the high prevalence of R/S issues within mental health (Mental Health Foundation, 1997) and the wish of patients to discuss R/S issues in mental health care (Bellamy *et al.,* 2007), it is important to examine how professionals are trained to work with R/S issues. Training programmes need to incorporate sufficient training in R/S issues from their individual perspectives and there needs to be support from professional bodies in doing this.

1.5.2. Research Limitations

A major limitation of this study was the broad nature of the topic. With tens-of-thousands of studies worldwide and even thousands within the UK, it is difficult to include these all. Excluded studies examining students, patients, and other health professionals, not just mental health, should be considered when examining the relationships and engagement of R/S within professional practice.

It is clear from the results of this research that R/S cannot be examined as a sole concept; there are many influential factors which impact on how professionals engage with R/S within practice. Specifically, the results highlighted barriers to engagement. Despite being useful, these barriers were not specifically addressed in the primary research papers and was not the aim of the review, therefore it is difficult to draw any firm conclusions; further examination of the barriers in detail is needed.

The literature search process yielded largely qualitative papers; this may have been due to the research question being more oriented toward understanding professionals' views which is more suited to qualitative research. The difficulty with systematically reviewing qualitative research is the risk of de-contextualising the findings (Thomas & Harden, 2008). A thematic synthesis approach was adopted to aid with this, where a line by line coding of the text is recommended, however, due to limited time, this was not possible. Furthermore, analytical interpretations developed were reviewed by the research assistant, however, were only examined once before being accepted.

Lastly, a number of the studies selected for review were published papers of doctoral theses, which did not always fully explain methodologies, rationale or

presented only summary findings. Again due to time limitations, full theses were not obtainable for examination, which may yield more findings.

1.6. Conclusion

It is clear that professionals view R/S as important within mental health, however, a number of broad fundamental barriers, both at macro- and micro-level, have been highlighted to influence professional engagement. The evidence suggests that professionals want to include R/S into practice, but there needs to be a number of changes in practice in order to enable this.

More definition and commitment from professional bodies and corporate structures would enable staff to feel more supported and secure in how to work with R/S in clinical practice. This can be achieved by professional bodies engaging with research in R/S and apply this when developing guidelines for practice. Subsequently, this would guide training institutions which clearly need to address the lack of R/S teaching, especially important for religious professionals who may have ethical dilemmas between their personal beliefs and clinical issues.

Lastly, organisations need to be aware of ethical dilemma of professionals and should examine the boundaries and ethics of R/S in practice. There needs to be a greater synergy between patients and professionals when engaging with R/S and mental health practice. This should include creating clearer service pathways between religious leaders and support and mental health services.

1.7. References

Anderson, N., Heywood-Everett, S., Siddiqi, N., Wright, J., Meredith, J., McMillan, D. (2015). Faith-adapted psychological therapies for depression and anxiety: systematic review and meta-analysis. *Journal of Affective Disorders*, 176, 183–196.

Baker, M., & Wang, M. (2004). Examining connections between values and practice in religiously committed U.K. clinical psychologists. *Journal of Psychology and Theology, 32*(2), 126-136.

Behere, P. B., Das, A., Yadav, R., & Behere, A. P. (2013). Religion and mental health. *Indian Journal of Psychiatry*, *55* (Suppl 2), S187–S194. http://doi.org/10.4103/0019-5545.105526

Bellamy, C. D., Jarrett, N. C., Mowbray, O., MacFarlane, P., Mowbray, C. T., & Holter, M. C. (2007). Relevance of spirituality for people with mental illness attending consumer-centered services. *Psychiatric Rehabilitation Journal, 30*(4), 287-294.

Berry, N. (2015). How does the NHS compare with health systems in other countries? The Health Foundation. Retrieved from http://www.health.org.uk/sites/health/files/HowDoesTheNHSCompareWithHealthSystemsInOtherCountries.pdf

Bhugra, D. (2016). Mental health for nations. *International Review of Psychiatry, 28*(4), 342-374. doi:10.1080/09540261.2016.1211095

Blair, L. J. (2015). The influence of therapists' spirituality on their practice: A grounded theory exploration. *Counselling & Psychotherapy Research, 15*(3), 161-170

Boehnlein, J. K. (Ed.). (2008). *Psychiatry and religion: The convergence of mind and spirit*. American Psychiatric Pub.

Burford, B., Worrow, E., & Caspary, A. (2009). *Religion or Belief: A Practical Guide for the NHS*. Department for Health.

Caldwell, K., Henshaw, L., & Taylor, G. (2011). Developing a framework for critiquing health research: an early evaluation. *Nurse education today*, *31*(8), e1-e7.

Cook, C. C. (2004). Addiction and spirituality. *Addiction, 99*(5), 539-551. doi:10.1111/j.1360-0443.2004.00715.x

Cook, C. C., Goddard, D. & Westall, R. (1997). Knowledge and experience of drug use amongst church affiliated young people. *Drug and Alcohol Dependence*, 46, 9-17

Cook, C. C., Powell, A., Sims, A., & Eagger, S. (2011). Spirituality and secularity: professional boundaries in psychiatry. *Mental Health, Religion and Culture*, *14*(1), 35-42.

Crossley, J. P., & Salter, D. P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 78*(3), 295-313. doi:10.1348/147608305X26783

Curlin, F. A., Odell, S. V., Lawrence, R. E., Chin, M. H., Lantos, J. D., Meador, K. G., & Koenig, H. G. (2007). The relationship between psychiatry and religion among U.S. physicians. *Psychiatric Services, 58*(9), 1193-1198. doi:10.1176/appi.ps.58.9.1193

Dein, S. (2004). Working with patients with religious beliefs. *Advances in Psychiatric Treatment*,10:287-94.

Dein S. (2006). Religion, spirituality and depression: Implications for research and treatment. *Primary Care and Community Psychiatry,* 11(2):67-72

Dein S (2010) Judeo-Christian religious experience and psychopathology: The legacy of William James. *Transcultural Psychiatry,* 47:523- 547.

Dein, S., & Littlewood, R. (2005). Apocalyptic suicide: From a pathological to an eschatological interpretation. *International Journal of Social Psychiatry*, 51(3), 198-210

Dura-Vilà, G., Hagger, M., Dein, S., & Leavey, G. (2011). Ethnicity, religion and clinical practice: A qualitative study of beliefs and attitudes of psychiatrists in the United Kingdom. *Mental Health, Religion & Culture, 14*(1), 53-64. doi:10.1080/13674676.2010.495111

Eeles, J., Lowe, T., & Wellman, N. (2003). Spirituality or psychosis? - An exploration of the criteria that nurses use to evaluate spiritual-type experiences reported by patients. *International Journal of Nursing Studies, 40*(2), 197-206. doi:10.1016/S0020-7489(02)00061-5

El-Nimr, G., Green, L. L., & Salib, E. (2004). Spiritual care in psychiatry: Professionals' views. *Mental Health, Religion & Culture, 7*(2), 165-170. doi:10.1080/1367467032000157990

Fawcett, T., & Noble, A. (2004). The challenge of spiritual care in a multi-faith society experienced as a Christian nurse. *Journal of Clinical Nursing*, *13*(2), 136-142. doi:10.1046/j.1365-2702.2003.00870.x

Foskett, J., Marriott, J., & Wilson-Rudd, F. (2004). Mental health, religion and spirituality: Attitudes, experience and expertise among mental health professionals and religious leaders in Somerset. *Mental Health, Religion & Culture, 7*(1), 5-22. doi:10.1080/13674670310001602490

George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology,* 19, 102–116.

Gilbert, P. D. (2007). Spirituality and mental health: a very preliminary overview. *Current Opinion in Psychiatry, 20*(6), 594-598. doi:10.1097/YCO.0b013e3282f0eee1

Gilburt, H. (2015). Mental health under pressure. *The King's Fund*. Retrieved 15 March 2017, from https://www.kingsfund.org.uk/publications/mental-health-under-pressure

Gilburt, H., Peck, E. & Ashton, B. (2014). Service transformation: Lessons from mental health. *The Kings Fund*. Retrieved 15 March 2017, from https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf

Griffith, J. L. (2010). Religion that heals, religion that harms: A guide for clinical practice. Guilford Press.

Gubi, P. M. (2004). Surveying the extent of, and attitudes towards, the use of prayer as a spiritual intervention among British mainstream counsellors. *British Journal of Guidance & Counselling, 32*(4), 461-476.doi:10.1080/03069880412331303277

Gubi, P. M. (2009). A qualitative exploration into how the use of prayer in counselling and psychotherapy might be ethically problematic. *Counselling & Psychotherapy Research, 9*(2), 115-121. doi:10.1080/14733140802685312

Hefti, R. (2011). Integrating Religion and Spirituality into Mental Health Care, Psychiatry and Psychotherapy. *Religions*, *2*(4), 611-627. http://dx.doi.org/10.3390/rel2040611

Jackson, J., & Coyle, A. (2009). The ethical challenge of working with spiritual difference: An interpretative phenomenological analysis of practitioners' accounts. *Counselling Psychology Review, 24*(3-4), 86-99.

Johansson, C. (2008). What Keeps You Grounded? Davis Network PT.

Kabat-Zinn, J. (2003). Mindfulness-Based Interventions in Context: Past, Present, and Future. Clinical Psychology: *Science and Practice*, 10: 144–156. doi:10.1093/clipsy.bpg016

Khalaf, D., Hlais, S., Haddad, R., Mansour, C., Pelissolo, A., & Naja, W. (2014). Developing and testing an original Arabic religiosity scale. *Middle East Current Psychiatry,* 21(2), 127–138.

Koenig H.G. (2007). Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. *J Nerv Ment Dis,* 195:389-395.

Koenig, H.G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry*, 54, 283–291

Laudet, A. B., Morgen, K., & White, W. L. (2006). The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Step Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems. *Alcoholism Treatment Quarterly*, *24*(1-2), 33–73. http://doi.org/10.1300/J020v24n01_04

Leach, M.M., & Harbin, J.J. (1997) Psychological Ethics Codes: A Comparison of Twenty-four Countries, *International Journal of Psychology*, 32(3), 181-192, DOI: 10.1080/002075997400854

Martinez, S., & Baker, M. (2000). 'Psychodynamic and religious?' Religiously committed psychodynamic counsellors, in training and practice. *Counselling Psychology Quarterly,* 13(3), 259-264. doi:10.1080/09515070010027607

McVittie, C., & Tiliopoulos, N. (2007). When 2-3% really matters: The (un)importance of religiosity in psychotherapy. *Mental Health, Religion & Culture, 10*(5), 515-526. doi:10.1080/13674670601005471

Mental Health Foundation (1997). Knowing our own minds London, *Mental Health Foundation.*

Mental Health Foundation, (2007). The fundamental facts. http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental_facts_2007.pdf?view=Standard

Mir, G., Meer, S., Cottrell, D., McMillan, D., House, A., & Kanter, J. W. (2015). Adapted behavioural activation for the treatment of depression in Muslims. *Journal of Affective Disorders, 180*, 190-199. doi:10.1016/j.jad.2015.03.060

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(6): e1000097. doi:10.1371/journal.pmed1000097

Moreira-Almeida, A., Neto, F. L., & Koenig, H. G. (2006). Religiousness and mental health: a review. *Rev Bras Psiquiatr, 28*(3), 242-250.

National Institute for Health and Clinical Excellence. (2010). Scope: patient experience in adult NHS services: improving the experience of care for people using adult NHS services. London: NICE

Neeleman, J., & King, M. B. (1993). Psychiatrists' religious attitudes in relation to their clinical practice: A survey of 231 psychiatrists. *Acta Psychiatrica Scandinavica, 88*(6), 420-424. doi:10.1111/j.1600-0447.1993.tb03484.x

Office of National Statsictics. (2011). Census: Quick statistics for England and Wales. London: Office of National Statistics

Pargament, K.I. (2010). Religion and coping: The current state of knowledge. In Oxford Handbook of Stress and Coping; Folkman, S., Ed.; Oxford University Press: Oxford, UK; pp. 269- 288.

Plante, T. G. & Sherman, C. (2001). Research on faith and health: New Approach to old questions. In T. G. Plante & C. Sherman (Eds.), Faith and Health: Psychological Perspectives. New York: The Guilford Press.

Puchalski, C. M. (2001). The role of spirituality in health care. *Proceedings (Baylor University. Medical Center)*, *14*(4), 352–357.

Ramakrishnan, P., Dias, A., Rane, A., Shukla, A., Lakshmi, S., Ansari, B. K. M., & Bhat, J. (2014). Perspectives of Indian traditional and allopathic professionals on religion/spirituality and its role in medicine: basis for developing an integrative medicine program. *Journal of religion and health*, *53*(4), 1161-1175.

Rao, M. S. (2005). Spirituality in Psychiatry? *Psychiatry (Edgmont)*, *2*(9), 20–22.

Schrank, B., & Slade, M. (2007). Recovery in psychiatry. *Psychiatric Bulletin,* 31. 321-325. DOI: 10.1192/pb.bp.106.013425

Schwartz, C. (2003). Altruistic Social Interest Behaviors are Associated with Better Health. *Psychosomatic Medicine*, 65, 778-785.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*(1), 45.

Udell, L., & Chandler, C. (2000). The role of the occupational therapist in addressing the spiritual needs of clients. *The British Journal of Occupational Therapy, 63*(10), 489-494. doi:10.1177/030802260006301006

van Loon, A., van Schaik, A., Dekker, J., & Beekman, A. (2013). Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments. *Journal of Affective Disorders, 147*(1), 9-16. doi:10.1016/j.jad.2012.12.014

Van Praag H.M. (2009). The role of religion in suicide prevention. In: Wasserman D, Wasserman C, editors. Oxford Textbook of Suicidology and Suicide Prevention. Oxford: Oxford University Press; 2009. p. 7-12.

West, W. (1997). Integrating counselling, psychotherapy and healing: An inquiry into counsellors and psychotherapists whose work includes healing. *British Journal of Guidance & Counselling, 25*(3), 291-311. doi:10.1080/03069889700760261

West, W. (1998). Developing practice in a context of religious faith: A study of psychotherapists who are Quakers. *British Journal of Guidance & Counselling, 26*(3), 365-375. doi:10.1080/03069889800760321Wright *et al.,* 2014

Wright, J.M., Cottrell, D.J., Mir, G. (2014). Searching for religion and mental health studies required health, social science, and grey literature databases. *J. Clin. Epidemiol*. 67 (7), 800–810. http://dx.doi.org/10.1016/j.jclinepi.2014.02.017.

Wyatt, J. (2002). 'Confronting the Almighty God'? A Study of how psychodynamic counsellors respond to clients expressions of religious faith. *Counselling and Psychotherapy Research,* 2(3), 177-183.

Zisook, S., Balon, R., Bjorksten, K. S., Everall, I., Dunn, L., Ganadjian, K., Yoo, T. (2007). Psychiatry residency training around the world. *Acad Psychiatry, 31*(4), 309-325. doi:10.1176/appi.ap.31.4.309

Chapter 2: Empirical Paper

Examining the influence of religiosity and spirituality on the risk of suicidality amongst faith and non-faith communities.

Chapter Word Count: 7927

(excluding tables, figures and references)

Prepared for submission to:

Suicide & Life-Threatening Behavior

(see Appendix D for author guidelines)

2.1. Abstract

Research examining the relationship between religion and suicidality has been extensively debated. Evidence largely suggests that religion may play a role in protecting against suicidality, however negative feelings have been suggested to increase risk of suicide. The aim of this research is to examine whether the psychosocial forces of 'religiosity' and 'spirituality' influence 'suicidality' amongst 'Faith' and 'Non-Faith' communities. The study used a cross-sectional design to survey 231 participants from 8 different faith/non-faith groups. Factors of R/S were measured against factors of suicidality. Religious participants were found to experience higher levels of depression and have more suicidal beliefs than non-religious participants. A MANOVA showed that levels of R/S were not greater across any religious group and no particular group showed higher propensity toward suicidality. This study supports the notion that it is not specific belief systems that are important, but a more complex interplay between factors of R/S and suicidality. Findings support the proposal that negative religious coping is a significant risk factor in suicidality. Religious leaders need to be more aware of the harmful impact negative interpretations may have on individual's psychological health. Professionals and policy makers need to support religious communities in developing and improving mental health literacy skills.

Keywords: Religiosity/Spirituality, Suicidality, Suicidal Beliefs, Depression

2.2. Introduction

2.2.1. Suicidality

Suicide impacts millions of people every year, with the World Health Organisation (WHO) recognising suicide as one of twenty leading causes of deaths globally (WHO, 2013b). The UK is ranked at 59th in world in suicide rates (WHO, 2013b). More than 6000 people end their own life each year in the UK (International Association for Suicide Prevention [IASP], 2015), with ten times that number attempting suicide (Office of National Statistics [ONS], 2015). Suicide is defined as "the act of deliberately killing oneself" (WHO, 2013a); however, suicidality goes beyond this and encompasses numerous aspects including thoughts, behaviours, ideas, planning, potentially injurious behaviours and attempts (Wenzel, Brown & Beck, 2009).

Cognitive models have established that feelings and thoughts such as hopelessness, burdensomeness and un-lovability are strongly associated with suicide (Van Orden *et al.,* 2010). Prospectively, as many as 90% of suicides could be predicted by hopelessness (Beck, Brown & Steer, 1989). Many theories have recognised causal links to suicide to include aspects such as trait patterns of suicidal cognitions, low levels of resilience, social dissatisfaction and the capacity to self-harm through heightened feelings of anger, hostility and aggression (Amitai & Apter, 2012; Barzilay & Apter, 2014; McLean *et al.,* 2008; You *et al.,* 2011). State and trait anger has been associated with inwardly directed behaviours and higher potential for self-aggressive tendencies (Daniel, Goldston, Erkanli, Franklin & Mayfield, 2010; Giegling *et al.,* 2009).

When considering public health initiatives, policy holders must draw on social anthropological studies which examine suicidality. Wenzel, Brown, and Beck (2009) suggested that schemas play an important role in the development of suicidal states; specifically, schemas involving attitudes, beliefs and cognitions, have been found to be influenced by broad existential themes (e.g. Culture, Tradition, Religion).

Epidemiological studies have demonstrated how suicide rates vary between groups, with ethnicity and culture being important factors in determining risk and prevalence (Abdel-Khalek, 2004; Griffith & Bell, 1989). Furthermore, classical indicators for the risk of suicide have been found to vary amongst different ethnic groups (Bhui, Dinos & McKenzie, 2012). Ethnicity and culture, however, are not the sole aspects in which variations have been found. The pioneering work of Durkheim (1897) highlighted the need for a sociological perspective and issues of social integration and religion in understanding suicide.

2.2.2. Religiosity, Spirituality and Suicidality

The relationship between religion and mental health has been subject to debate for more than a century (Cook, 2014). Largely, evidence has suggested that those with no religious affiliation have poorer mental health levels (Hall, Koenig & Meador, 2008) and much of the research suggests that religiosity and spirituality (R/S) have a protective influence over mental health (Cook, 2014). However, a particular shortfall has been the ambiguity as to the specific mechanisms associated with religion which influence health outcomes and well-being (Behere, Das, Yadav & Behere, 2013). It has been suggested that several aspects within R/S are related (Fisher, 2011). With research

demonstrating the relationship between mental health and suicide, much of this has branched out to explore the relationship between R/S and suicide (Moreira-Almeida, Koenig & Luchetti, 2014).

2.2.2.1. Religiosity/Spirituality as Protective Factors against Suicidality

Studies around the world have found varying rates and shifting trends of suicide within their populations (WHO, 2013b). Specifically, suicide rates have been shown to be lower in religious countries over secular countries (Dervic *et al.,* 2004); this is not surprising as countless empirical evidence has shown that religion can be protective against suicide (Cook, 2014).

In a systematic review examining religion and suicide risk, it was highlighted that religious affiliation is protective against suicide attempts (Lawrence, Oquendo & Stanley, 2016); however, they also comment that affiliation alone is not protective, and it could be due to multiple factors associated with religion. For example, sanctions against behaviours and moral objections to suicide have been found to be protective against suicide (Koenig *et al.,* 2001; Lizardi *et al.,* 2007). Also religious service attendance could provide social support which is protective against suicide attempts (Lawerence, Oquendo & Stanley, 2016). Other religious behaviours such as prayer, meditation, confession have been suggested to have similar effects to psychological therapies (e.g. CBT) which can be protective against suicidal thoughts, depression, anxiety, guilt and/or anger (Hefti, 2011). This can also allow individuals to feel connected to a 'higher power' which can give people the feeling of being loved and being important (Capaldi, Dopko & Zelenski, 2014).

Furthermore, studies have shown that R/S can provide individuals with hope, reassurance, meaning and direction in life (Osafo, Knizek, Hjelmeland, &

Akotia, 2013), which can counteract thoughts of hopelessness often associated with suicide. Moreover, studies have demonstrated that hope and optimism associated with R/S reduces the risk of depression and increasing coping during stressful life events which can be protective against the risk of suicide (van Praag, 2009).

2.2.2.2. Religiosity/Spirituality as Potential Risk Factors for Suicidality

Despite evidence generally suggesting R/S is protective against mental health and suicide, there are inconsistencies in the research, with some evidence suggesting it contributes to increased risk (Zhao *et al.,* 2012). For example, a recent systematic review found that although religious affiliation and service attendance appears to be protective against suicide attempts, it does not appear to be protective against suicidal ideation (Lawerence, Oquendo & Stanley, 2016).

A limited amount of research has specifically examined 'negative religious coping' which relates to religious/spiritual struggles individual face such as punishment, rejection or abandonment (Pargament, 1997); which have been suggested to increase risk of suicide (Pargament, Smith, Koenig, & Perez, 1998). Additionally, religious/spiritual behaviours such as fasting may increase health risks (Ineichen, 1998) and indirectly increase suicide risk. A longitudinal study examining prayer found an increased risk for suicidal ideation in adolescents who prayed regularly, compared to those who never pray (Nkansah-Amankra et al., 2012); it may be that external stressful life factors eventually outweigh coping that prayer provides.

Research has also proposed that R/S may lead individuals to create higher standards that are difficult to attain (Exline, 2002), leading to a sense of failure

and possibly rejection from faith communities and social isolation. This may increase risk of depression and consequently increase the risk of suicide. Also, religious beliefs have been shown to be associated with excessive guilt in difficult situations or negative events (Koenig, 2007); guilt has been shown to increase the risk of suicide.

2.2.3. Religion and Spirituality

Religion can take on many forms (e.g. Christian, Hindu etc..). Despite the differences, many commonalities can be found when defining the concept of religion. Religion can be understood as socially constructed systems, which can be physically identified by externally facing structures (e.g. church etc..), with prescribed theological beliefs contained in scriptures (e.g. bible etc..) and forms of shared worship (Harrison, 2006).

Research has highlighted the degree to which different faith traditions differ in terms of religious practices (Cohen and Hill, 2007); for example, Protestants report higher levels of intrinsic religion (i.e. the importance of a personal relationship with God) whereas, Jews report being the most involved in extrinsic religion (i.e. religious rituals/activities). Furthermore, within each religion, members can be differentiated by their degree of 'religiosity'; their commitment to a series of psychosocial and behavioural aspects of engagement.

More specifically, 'religiosity' is generally defined in terms of 5 principal areas (Koenig *et al.*, 2001): (1) religious attachment; a person's degree of commitment to their faith's beliefs within their daily lives, and their involvement in faith activities such as attending religious services, engagement in community work and frequency/meaning of the worshiping experience; (2)

'religious support'; the role their faith plays in establishing caring personal and social relationships; (3) 'religious coping'; whereby their faith is viewed as a benevolent force which is used to help make sense of social difficulties; (4) 'religious forgiveness'; a psychosocial mechanism within one's faith that helps to manage feelings of guilt and distress. Religiosity in the form of forgiveness can manifest through dimensions such as: confessing sins, feeling forgiven by God and others, and forgiving others for their wrongdoing as well as learning to forgive oneself; (5) 'religious values'; this final element of 'religiosity' centres on how beliefs within one's faith are used to shape normative practices about a particular social issue.

'Spirituality' is understood as a force that transcends individual faith-based beliefs so that it is possible to be 'spiritual' without being religious (Moreira-Almeda *et al.,* 2006). Existentially, it is a subjective experience about the meaning of existence which is defined through the perspective of a higher power such as God. However, spirituality transcends religion in the sense that this higher power does not necessarily need to be a Deity; it could instead be 'love', 'compassion', or 'luck'. These higher forces help individuals interpret the meaning behind life's events in two principal ways: (1) in terms of 'process'; what a person does to find meaning (e.g. worship God, practice yoga or mindfulness, believe in astrology or palmistry); (2) 'outcome'; a person's degree of success in reaching a personally satisfying, life-fulfilling conclusion.

2.2.4. Rationale

Research examining the relationship between R/S and suicidality has been extensively debated (Lawerence, Oquendo & Stanley, 2016) and often has focussed on differences between religions (Moreira-Almeida, Koenig &

Luchetti, 2014). Whilst important to examine different religious belief systems, this does not necessarily provide sufficient explanation in differences between levels of religiosity in individuals and the relationship to suicidality. Furthermore, previous research has largely focussed on individual religions, or considered religious affiliation with any group as representative of all groups (Lawerence, Oquendo & Stanley, 2016). It is important to consider a wide range of faith communities when examining the impact of religiosity and spirituality. It is also important to include non-faith groups such as Atheists and those who do not subscribe to any religion but may hold spiritual beliefs.

An area of difficulty which is relevant to the present study is the measurement of 'religiosity' and 'spirituality' (Lowenthal, 2000); this is particularly difficult when attempting to compare people from diverse religious/spiritual backgrounds. The five principal areas described above, have been found to suitably describe religiosity (Koenig *et al.*, 2001) and two principal areas in spirituality (Moreira-Almeda *et al.,* 2006). These will be used to define R/S.

Evidence largely suggests that R/S may play a role in protecting against suicidality, however this research is filled with problems. In particular, psychosocial forces can have a negative impact on people in terms of: the demands and expectations placed on how one should think and behave, and encouraging thoughts and feels about higher powers such as God who is seen as either punishing or has abandoned those in psychological distress.

Finally, suicidality is difficult to measure (Nock *et al.,* 2010), however, as the evidence-base suggests that its origins are rooted in several key psychosocial factors, they will all be included in the study. Thus, suicidality will be defined across a number of psychosocial factors, namely: depression, satisfaction with

life, resilience, anger/aggression, suicidal behaviour and patterns of suicidal cognitions. A general measure of depression, rather than hopelessness, was selected to encapsulate global difficulties people face, including feelings/thoughts of loneliness, hopelessness, worry, isolation and suicide.

2.2.4.1. Aims and Research Questions

The aim of this research is to examine whether the psychosocial forces of 'religiosity' and 'spirituality' influence 'suicidality' amongst both 'Faith' and 'Non-Faith' communities. The primary goal of this project is not to assess the impact of specific belief systems within each religion per se. Instead, the main focus is on measuring the degree of 'religiosity' and 'spirituality' held by individuals amongst these 'Faith'/'Non-Faith' communities and how they influence 'suicidality'.

Specifically, the study will attempt to answer the following three questions:

1) Is there a difference between Faith and Non-Faith communities in their propensity towards suicidality?
2) Can any differences between Faith and Non-Faith community's propensity towards suicidality be explained through religious affiliation?
3) Can any differences between Faith and Non-Faith community's propensity towards suicidality be explained through the elements of 'religiosity' and 'spirituality'?

2.3. Method

2.3.1. Research Design

The present study aimed to understand relationships between different groups. As such this study was in the form of a cross-sectional e-survey

design. A series of self-report questionnaires, using fixed responses in the form of a traditional Likert-type format was used. This approach enabled the study to obtain quantitative data from different faith/non-faith communities within the general population.

The study employed purposive quota sampling method to obtain an evenly distributed sample population. The method also fits with the positivist epistemological position and allows for the data to be representative of a general population sample.

2.3.2. Recruitment and Participants

To recruit a diverse range of participants several methods of advertisement were used. Advertisement was targeted at religious groups and organisations through social media (Facebook, Twitter etc..); direct contact with places of worship; university chaplaincies and student religious organisations; local organisations such as the NHS; and word-of-mouth. Discussion and advertisement was also carried out with local faith councils to promote research. A research assistant also advertised the survey by directly approaching local organisations/places of worship and promoting the survey. A research poster was developed for the purpose of advertising (see appendix E).

The aim was to have a broadly even number of participants representing each religious group. Recruitment of participants was actively monitored by the lead author to target groups with lower numbers. Subsequent advertisement attempts were made to target religious groups with lower numbers by both the lead author and research assistant.

2.3.3. Materials

Data was gathered via the Bristol Online Surveys (BOS) tool, which is a Coventry University policy approved web-based service.

The principal aims of this study operationalise 4 complex concepts: 'religion/non-faith', 'religiosity', 'spirituality' and 'suicidality'. This will be achieved using 7 fixed response measures which have demonstrated good psychometric properties and have been widely employed in this subject area (see appendix F for further psychometric details on each). A copy of all questions used can be found in appendix G.

- **Demographic Information**

Relevant demographic information was collected using questions employed by the UK census. This included questions about religious beliefs, ethnicity, age, educational level and gender. Age in years was measured as opposed to date of birth to avoid identifiable information.

- **Modified Multi-Dimensional Measure of Religiosity/Spirituality (MMRS)**

Religiosity/Spirituality was measured using a modified version of the Fetzer Institute (2003) Multi-Dimensional Measure of Religiosity/Spirituality (MMRS). The MMRS is an assessment tool drawing on several different tools which measure religiosity and spirituality. Use of the full measure was not felt to be necessary within this project as religiosity and spirituality were predefined. Specific questions were chosen in order to explore the following areas: (1) religious attachment; (2) religious support; (3) religious coping; (4) religious forgiveness; (5) religious values. Questions for spirituality were also selected

which cover the following areas: (1) ‘process’; what a person does to find meaning (e.g. worship God, practice yoga or mindfulness, believe in astrology or palmistry); (2) ‘outcome’; a person’s degree of success in reaching a personally satisfying, life-fulfilling conclusion.

- **Suicide Cognitions Scale (SCS) (Rudd, 2007)**

The SCS is a self-report measure consisting of 18 items that considers the negative cognitions of person having suicidal ideations. It specifically targets person's belief system constructing hopelessness characteristics. The scale measures the strength of beliefs consistent with suicidal schemas of un-bearability and un-lovability. The scale is scored on a 5-point scale, with scores ranging from 18 – 90. The SCS is a free to use highly validated measure.

- **Suicide Behaviours Questionnaire-Revised (SBQ-R) (Osman *et al,* 2001)**

The SBQ-R is a 4-item self-report measure that considers the experience of suicidal ideation, planning and attempts of a person. The SBQ-R has been found to be a valid and reliable tool for adults (Osman *et al.,* 2001).

- **Patient Health Questionnaire (PHQ-9) (Spitzer *et al.,* 1999)**

The PHQ-9 is a 9-item self-report measure of depressive symptoms frequently used in clinical practice. Total scores range from 0 – 27, with a cut-off of 5 for mild depression, 10 for moderate depression, 15 for moderately severe depression and 20 for severe depression.

- **Modified Anger and Aggression Scale (Buss & Perry, 1992)**

The Buss and Perry aggression questionnaire is a 29 item measure of aggression in adults, consisting of 4 domains: Physical aggression, Verbal

aggression, Anger, and Hostility. Specific questions regarding physical and verbal aggression, hostility, anger and clinical anger were selected for use as these have shown traits and associations in relation to suicidal thoughts and ideations.

- **Satisfaction with life (WHOQOL-BREF) (WHOQOL Group, 1998)**

Ten items from the WHOQOL-BREF were used. These broadly covered life satisfaction for physical and psychological health, social relationships and environmental domains.

- **Brief Resilience Scale (BRS) (Smith *et al.,* 2008)**

The BRS is a self-report measure to assess resilience as an outcome; defined as the ability to 'bounce back' or recover from stress. It is a 6-item scale on a 5 point Likert scale; with 3 positive and 3 negative items.

2.3.4. Ethics

Ethical approval was granted by Coventry University Ethics Committee (see appendix H). The study was also approved by Research and Development departments for advertisement within University Hospitals Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust to staff; however formal ethical approval was not required. Permission to advertise through other organisations was sought prior to doing so, however, no formal ethics approval was required for any other organisations. The study was designed in accordance with guidance by the British Psychological Society Code of Ethics and Conduct (BPS, 2010).

As data for the study was collected anonymously via BOS, several ethical issues needed to be considered.

The main inclusion criteria for the study was adults over the age of 18; as an anonymous public survey anybody would have access to the survey. A participant information sheet (PIS) (see appendix I) was presented on the front page; this included information about the purpose of the study, the contents of the survey and information regarding the process. Participants were required to complete a consent form (see appendix J) stating they have read the PIS and confirm they are over the age of 18. Consent was via opt-in. No participants reported to be under the age of 18.

Participants were made aware via the PIS, that taking part was voluntary and anonymous. Furthermore, due the data being anonymous, they were made aware that once their data had been submitted, it was not possible to withdraw the information. A prompt to confirm this before submission was also provided.

Due to the sensitive nature of some the questions, participants were provided with information for relevant support services in the PIS. The lead authors contact details were also available if any participants had specific questions about the study. The option to save and return to the survey was also provided so that participants could take a break if they felt overwhelmed. Information regarding support services was repeated at the end of the survey within the Debrief Sheet (DS) (see appendix K). No participants contacted the lead author due to distress.

2.3.5. Analysis

Data was extracted and coded by BOS in a suitable format for analysis and downloaded to a secure university computer. Results were analysed using SPSS ® (version 24, IBM Corp). Several descriptive and inferential statistics were conducted in order to explore the primary research questions. The study

used a mixed method data analysis using independent groups. Each research question will be presented in the results section along with the appropriate data analysis.

Independent variables for all 3 research questions focus on participant's religious beliefs. Dependent factor variables included measures associated with suicidality (depression, anger/aggression, suicidal cognitions, suicidal ideations, satisfaction with life and resilience). Eight continuous Dependent Variables were created from these measures. These include Total Suicide (SCS, SBQ-R), Total Depression (PHQ-9), Total Satisfaction with Life (WHOQOL-BREF), Total Resilience (BRS), Total Aggression (physical/verbal aggression questions), Total Hostility (hostility questions), Total Anger (anger questions), Total Clinical Anger (clinical anger questions).

2.4. Results

2.4.1. Demographics

Despite targeted advertising, there were disparities in the number of participants between religious groups. A total of 231 participants took part in the survey. Participants self-declared religious groups were: Buddhist (1.3%), Jewish (0.9%), Muslim (3.9%), Sikh (3.5%), Agnostic (1.7%), Atheist (10.8%), No Religion (23.8%), Christian (27.3%), Hindu (22.1%), Other (3.9%). Two participants had missing data were excluded from the data analysis process.

For inferential analysis data regarding participants' beliefs was to be recoded due to low numbers in certain groups and disparity across the groups. This

was achieved in 2 ways in order to answer the research questions. Initially participants were grouped either as 'Not Religious Group' (NRG) which included 'No Religion' and 'Atheist' or as 'Religious Group' (RG) which included all other groups. Secondly, low number groups were merged into a single religious group labelled 'Other Religions'; this included Buddhist, Jewish, Muslim, Sikh, Other, Agnostic. Figure 2.1. shows the frequencies of participants in religious groups once recoded. These groups form the basis for future analysis.

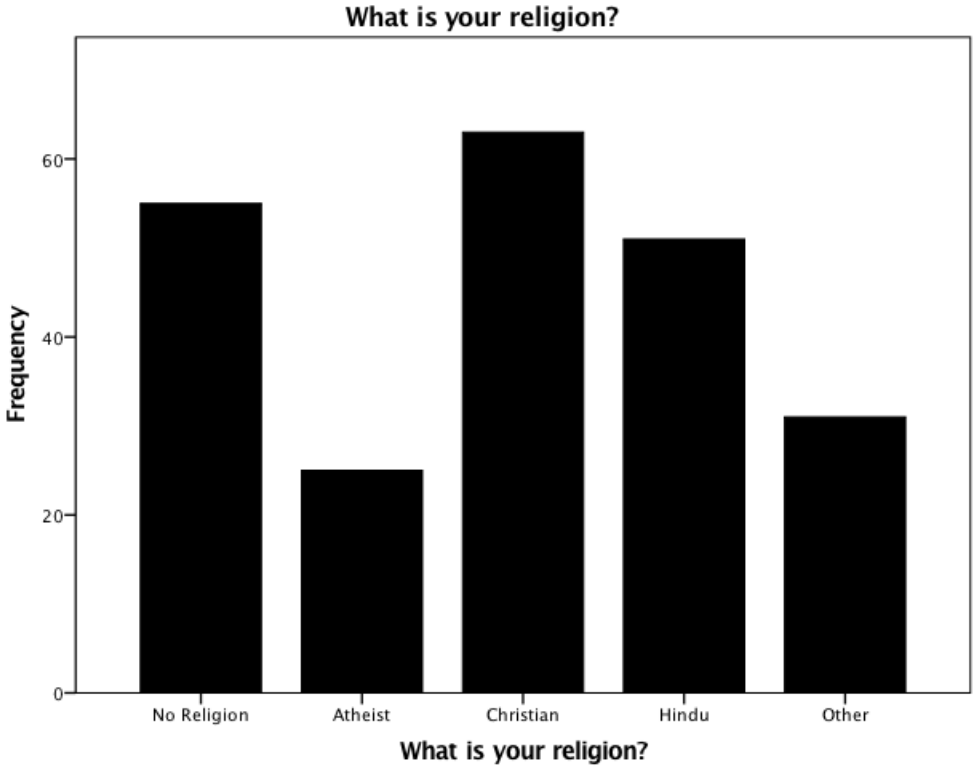


Figure 2.1. Recoded religious groups frequencies

The majority of participants were female (23.4% male and 73.6% female); 6 participants had missing data. The difference for these proportions across religious groups is not statistically significant via Chi Square X^2 (4) = 8.54, p = .074; we can therefore assume there is a gender balance across the groups, even though overall proportions are unbalanced.

Participants age ranged from 18 - 71 (M = 34.27, SD = 12.11). This was found to be not normally distributed with a positive skewness value (1.08) and positive kurtosis values (.258) which suggests there is a higher number of younger people than older people in the dataset. We can see from Figure 2.2. (below) that this held true when examining the distribution of age across different religious groups.

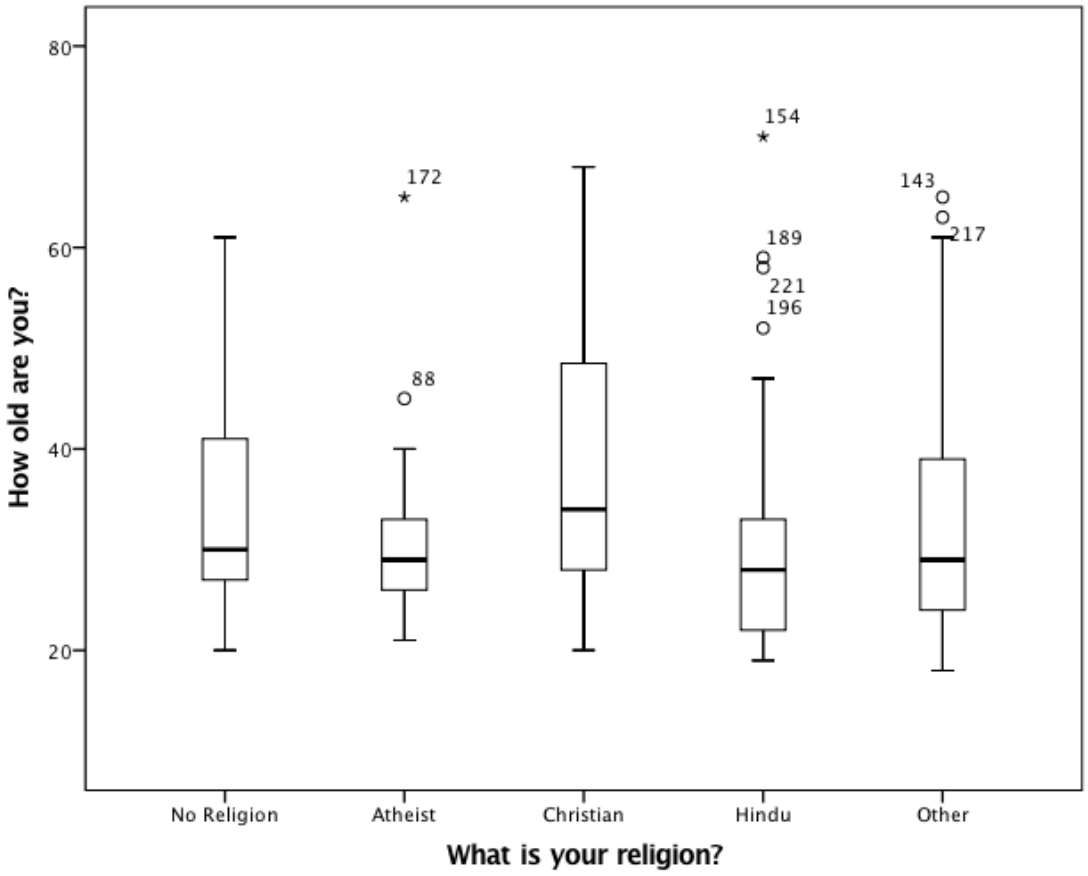


Figure 2.2. Distribution of Age across groups.

Generally, participants were well educated, to at least degree level (35.1%) or higher degree (42%). The difference for these proportions across religious groups is not statistically significant via Chi Square X^2 (72) = 50.01, p = .977; we can therefore assume educational levels across groups was proportionate. The majority of participants described English as their main language (90.9%), and were white (64.1%), Asian (31.6%), Black (0.9%), Mixed (1.7%).

2.4.2. Is there a difference between Faith and Non-faith community's propensity toward suicidality?

In order to answer the first research question, the IV was recoded to form RG (*N* = 142) or NRG (*N* = 77) (as described in section 2.4.1) along with the 8 continuous dependent variables (Total Suicide, Total Depression, Total Satisfaction with Life, Total Resilience, Total Aggression, Total Anger, Total Clinical Anger) (as described in section 2.3.5.). An independent samples t-test was conducted to test whether there was any significant difference between religious and non-religious participants.

Suicidality DV	Groupings IV	Mean Scores	Sig. (p)
Total Suicide	Non-Religious	26.82	.026*
	Religious	30.95	
Total Depression	Non-Religious	15.24	.016*
	Religious	17.39	
Total Satisfaction with Life	Non-Religious	37.53	.737
	Religious	37.83	
Total Resilience	Non-Religious	20.18	.412
	Religious	19.59	
Total Aggression	Non-Religious	10.28	.513
	Religious	10.52	
Total Hostility	Non-Religious	5.68	.839
	Religious	5.73	
Total Anger	Non-Religious	5.43	.076
	Religious	5.88	
Total Clinical Anger	Non-Religious	5.37	.489
	Religious	5.52	

Table 2.1. Mean differences between religious and non-religious faith groups.

*Note: * indicates a significant mean difference*

The independent samples t-test found that on average religious participants have significantly higher suicidal beliefs (*M* = 30.95, *SE* = 1.32) than non-religious (*M* = 26.82, *SE* = 1.22), *t* (55.37) = -2.29, p = .026. Furthermore, it can be seen that on average religious participants also have significantly higher levels of depression (*M* = 17.39, *SE* = .61) than non-religious participants (*M* = 15.24, *SE* = .65), *t* (192.78) = -2.43, p = .016.

Religious participants did not significantly differ from non-religious participants in terms of satisfaction with life (*t* (220) = -.34, p = .737); resilience (*t* (221) = .82, p = .412) anger (*t* (223) = -1.79, p = .076); aggression (*t* (219) = -.66, p = .513); clinical aggression (*t* (198.91) = -.69, p = .489); and hostility (*t* (220) = -.20, p = .839).

As can be seen in table 2.1. above both, level of depression and suicidal beliefs seem to indicate a difference between religious and non-religious groups (see appendix L for detailed output) with religious people experiencing higher levels of depression and more suicidal beliefs; however, none of the other variables significantly differed between religious and non-religious participants.

2.4.3. Can any differences between Faith and Non-Faith community's propensity toward suicidality be explained through specific religious affiliation?

The second research question seeks to examine whether these results hold true when examining specific religious groups. In other words, does membership of a particular religious group show a greater propensity towards depression and/or suicidal beliefs?

In order to answer this question, a multivariate analysis of variance (MANOVA) was used. This was selected due to measuring the 8 continuous DVs and assures more statistical accuracy and in turn confidence in findings by reducing the risk of Type 1 errors. As described above, the IV was recoded to have 5 categories due to low numbers in certain groups: No Religion, Atheist, Christian, Hindu, and Other (Muslims, Jews, etc.).

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Q14	Wilks' Lambda	.897	1.396	16.000	617.758	.137	.027
Q14	Wilks' Lambda	.920	1.107	16.00	639.143	.344	.021

Table 2.2. MANOVA for Depression and aggression

Using Wilks' Lambda (table 2.2.), there was no significant difference across religious groups in level of depression $\Lambda = .897$, F (16, 617.76) = 1.40, p = .137. Separate univariate ANOVAs (table 2.3.) on the suicidality outcome variables confirmed non-significant differences for suicidal beliefs (F (4, 205) = 1.63, p = .169); depression (F (4, 205) = 1.47, p = .213); satisfaction with life (F (4, 205) = .13, p = .971); and resilience (F (4, 205) = .67, p = .614).

Source	DV	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Q14	TotalSuicide	1037.51	4	259.38	1.63	0.169	0.031
	TotalDepress	272.46	4	68.12	1.47	0.213	0.028
	TotalSatLife	23.21	4	5.80	0.13	0.971	0.003
	TotalResl	70.13	4	17.53	0.67	0.614	0.013
	TotalAggress	48.38	4	12.10	1.78	0.134	0.032
	TotalHostility	10.83	4	2.71	0.67	0.611	0.013
	TotalAnger	17.85	4	4.46	1.33	0.260	0.024
	TotalClinAng	16.60	4	4.15	1.35	0.253	0.025

Table 2.3. Univariate ANOVA for measures of suicidality

Using Wilks' Lambda (table 2.2.), no significant difference was found across religious groups in levels of aggression Λ = .920, *F* (16, 639.14) = 1.11, p = .344. Separate univariate ANOVAs (table 2.3.) confirmed non-significant differences for aggression (*F* (4, 212) = 1.78, p = .134); hostility (*F* (4, 212) = .67, p = .611); anger (*F* (4, 212) = 1.33, p = .260); and clinical anger (*F* (4, 212) = 1.35, p = .253).

While being religious shows a significant difference in the propensity towards both depression and suicidal beliefs (research question 1 above), an explanation for this difference does not appear to be accounted for through participant's religious affiliation per se. This suggests that aspects of 'religiosity' and 'spirituality' may be more important.

2.4.4. Can any differences between Faith and Non-Faith community's propensity toward suicidality be explained through elements of 'religiosity' and 'spirituality'?

2.4.4.1. Religious Attachment

Religious attachment is the degree of 'commitment' and 'involvement' within 'Faith' communities. Religious commitment refers to the role religion plays in people's everyday life; a new variable was derived to measure this, called 'TotalRelComit'. Religious involvement is defined in terms of: history (brought up within a religion) attendance, membership, outside worship activities, persons 'fit' to congregation and their Worship Experience). A new variable was derived to measure this, called 'TotalRelInv'.

2.4.4.1.1. Religious Commitment

An independent samples t-test was conducted to see if there is a difference in commitment between non-religious and religious groups in general. On average religious participants (*M* = 15.28, *SE* = .31) were significantly more committed that non-religious participants (*M* = 10.46, *SE* = .34), *t* (222) = -9.89, p < .001. It can be seen that religious commitment plays a more important role in religious people's lives, however it is important to know if this is greater for any particular group.

	No Religion	Atheist	Christian	Hindu
Other	***	***	*ns*	*ns*
Hindu	***	***	*ns*	
Christian	***	***		
Atheist	*ns*			
No Religion				

Table 2.4. Tukey's HSD post-hoc multiple comparisons for total religious commitment

*Note: *** indicates a significant mean difference at p < .001; ns indicates no significant difference*

An analysis of variance (ANOVA) yielded significant variation between groups *F* (4, 219) = 26.15, p < .001. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other (p = .999), but differ from all other religious groups (p < .001). All religious groups do not differ from each other in their overall level of religious commitment (see table 2.4.).

2.4.4.1.2. Religious Involvement

An independent samples t-test was conducted to see if there is a difference in involvement between non-religious and religious groups in general. On

average religious participants (*M* = 39.86, *SE* = 1.24) were significantly more involved that non-religious participants (*M* = 14.72, *SE* = .58), *t* (193.59) = -18.36, p < .001.

An ANOVA yielded significant variation between groups *F* (4, 213) = 51.59, p < .001. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other (p = .925), but differ from all other religious groups (p < .001). All religious groups do not significantly differ from each other in their overall level of religious commitment (see appendix L for detailed output).

2.4.4.2. Religious Support

Religious support is the role of religion in establishing caring personal and social relationships. This support is about several elements, namely: emotional support received from fellow parishioners; emotional support given to others in one's congregation; and anticipated support. A new variable was derived called 'TotalRelSupport'.

2.4.4.2.1. Positive Support

An independent samples t-test was conducted to see if there is a difference in religious support between non-religious and religious groups in general. On average religious participants (*M* = 15.42, *SE* = .68) received significantly more support that non-religious participants (*M* = 6.91, *SE* = .37), *t* (205.83) = -11.05, p < .001.

An ANOVA yielded significant variation between groups *F* (4, 217) = 20.57, p < .001. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other (p = .927), but differ from all other

religious groups ($p < .001$). All religious groups do not differ from each other in their overall level of religious support (see appendix L for detailed output).

2.4.4.2.2. Negative Support

Religion can also represent a negative, rather than supportive, impact. This was measured on whether people in congregation were demanding and critical. An independent samples t-test was conducted to see if there is a difference in negative impact of religious support between non-religious and religious groups in general.

On average, religious participants ($M = 1.91$, $SE = .08$) felt that members of their congregation made significantly more demands on them than non-religious participants ($M = 1.13$, $SE = .06$), t (220.95) = -7.73, $p < .001$. Furthermore, religious participants ($M = 2.04$, $SE = .09$) also felt that their congregation were significantly more critical of them than non-religious participants ($M = 1.14$, $SE = .07$) t (221.84) = -7.86, $p < .001$.

A MANOVA using Wilks' Lambda found a significant difference across groups negative religious support $\Lambda = .752$, F (8, 434) = 8.292, $p < .001$. Separate univariate ANOVAs confirmed significant difference between religious groups for demands from congregation (F (4, 218) = 11.87, $p < .001$) and criticism from congregation (F (4,218) = 13.36, $p < .001$). A post-hoc analysis using Dunnett T3 revealed that non-religious and atheist participants do not significantly differ from each other for either level of demands ($p = .323$) or criticism ($p = .322$) from their congregation, but significantly differ from all other religious groups ($p < .001$). All religious groups do not significantly differ from each other ($p > .05$) (see appendix L for detailed output). Here the data

suggests that religion places a significant level of negative consequences on participants.

2.4.4.3. Religious Coping

Religious coping can have two aspects, positive and negative: (1) positive religious/spiritual coping is reflective of benevolent religious methods of understanding and dealing with life stressors; a new variable was derived called 'TotalRelPosCope', and (2) negative religious/spiritual coping reflective of religious struggle in coping.

2.4.4.3.1. Positive Coping

An independent samples t-test was conducted to see if there is a difference in positive coping between non-religious and religious groups in general. On average religious participants reported significantly higher levels of positive religious coping (M = 8.17, SE = .25) than non-religious participants (M = 3.49, SE = .122), t (196.61) = -16.70, p < .001.

An ANOVA yielded significant variation between groups F (4, 217) = 45.65, p < .001. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other (p = .993), but differ from all other religious groups (p < .001). All religious groups do not significantly differ from each other (see appendix L for detailed output).

2.4.4.3.2. Negative Coping

Negative religious coping was defined by two questions: (1) viewing God as punishing (Punishing God Reappraisal); (2) viewing God as abandoning (Spiritual Discontent).

An independent samples t-test was conducted to see if there is a difference in negative coping between non-religious and religious groups in general. On average, religious participants report significantly more thoughts about punishment (*M* = 1.46, *SE* = .07) than non-religious participants (*M* = 1.06, *SE* = .03), *t* (292) = -5.34, p < .001. Furthermore, religious participants reported significantly more thoughts about abandonment (*M* = 1.34, *SE* = .06) than non-religious participants (*M* = 1.03, *SE* = .03), *t* (190.39) = -4.95, p < .001.

A MANOVA using Wilks' Lambda found a significant difference across religious groups negative religious support Λ = .822, *F* (8, 436) = 5.62, p < .001. Separate univariate ANOVAs confirmed significant difference between religious groups viewing God as punishing (*F* (4, 219) = 9.71, p < .001) and feeling abandoned (*F* (4,218) = 7.27, p < .001). A post-hoc analysis using Dunnett T3 revealed that non-religious and atheist participants do not significantly differ from each other for either punishment (p = .434) or abandonment (p = .975) from their congregation, but significantly differ from all other religious groups (p < .001). However, it was found that Hindu's held significant more negative views regarding punishment (*M* = 1.73) than Christians (*M* = 1.21) p = .006, but not for abandonment p = .094 (see appendix L for detailed output).

2.4.4.4. Religious Forgiveness

Religious forgiveness includes 5 dimensions of forgiveness: confession, feeling forgiven by God, feeling forgiven by others, forgiving others, and forgiving oneself.

DV	Groupings IV	Mean Scores	Sig. (p)
Q59 It is easy for me to admit that I am wrong.	Non-Religious	2.89	.006*
	Religious	3.15	
Q60 I believe that God has forgiven me for things I have done wrong.	Non-Religious	1.22	.000*
	Religious	2.94	
Q61 I believe that there are times when God has punished me.	Non-Religious	1.08	.000*
	Religious	1.73	
Q62 I often feel that no matter what I do now, I will never make up for the mistake I have made in the past.	Non-Religious	1.69	.006*
	Religious	2.03	
Q63 I am able to make up pretty easily with friends who have hurt me in some way.	Non-Religious	2.88	.951
	Religious	2.87	
Q64 I believe that when people say they forgive me for something I did, they really mean it.	Non-Religious	2.95	.718
	Religious	2.91	
Q65 If I hear a sermon, I usually think about things I have done wrong.	Non-Religious	1.28	.000*
	Religious	2.72	
Q66 I have grudges which I have held onto for months or years.	Non-Religious	2.05	.665
	Religious	2.00	
Q67 I have forgiven myself for things that I have done wrong.	Non-Religious	2.84	.612
	Religious	2.78	
Q68 I often feel like I have failed to live the right kind of life	Non-Religious	1.74	.004*
	Religious	2.10	

Table 2.5. Independent samples t-test for religious forgiveness

*Note: * indicates a significant mean difference.*

An independent samples t-test (see appendix L for detailed output) found that on average religious participants are significantly more likely to admit when they are wrong (t (222) = -2.77, p = .006); believe that God forgives them (t (221.38) = -14.81, p < .001); view God as more punishing (t (199.81) = -8.20,

p < .001); believe they can't make up for mistakes in the past (*t* (198.56) = -2.79, p = .006); think about things they have done wrong whilst listening to a sermon (*t* (222.977) = -10.87, p < .001); and feel that they have failed to live right kind of life (*t* (223) = -2.92, p = .004). It could be suggested that religiosity may not always be about a sense of forgiveness, especially of oneself.

2.4.4.5. Religious Values

Religious values refer to the influence of religion on normative practices, such as the importance of religious values as a coping mechanism; beliefs in life after death; and attitudes towards suicide.

An independent samples t-test (see appendix L for detailed output) found that on average religious participants placed significantly higher importance on religious values in daily life (*t* (217.74) = -14.38, p < .001) and were significantly more likely believe in life after death (*t* (143.86) = -12.14, p < .001).

A one-way ANOVA found significant difference in belief of life after death between religious and non-religious participant's *F* (4, 220) = 42.20, p < .001. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other (p = .323), but differ from all other religious groups (p < .001). All religious groups do not significantly differ from each other in their overall level of religious commitment (see appendix L for detailed output).

A one-way ANOVA found a significant difference in importance of religious values between religious and non-religious participant's *F* (4, 216) = 39.18, p < .001. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other (p = .889), but differ from all other religious groups (p < .001). All religious groups do not significantly differ from

each other in their overall level of religious commitment (see appendix L for detailed output).

2.4.4.5.1. Attitudes toward Suicide

DV	Groupings IV	Mean Scores	Sig. (p)
Suicide is an acceptable means of ending life in some situations.	Non-Religious	3.35	.000*
	Religious	2.57	
Suicide can never be justified under any circumstances.	Non-Religious	1.99	.000*
	Religious	2.77	
People who are suicidal can always be helped.	Non-Religious	3.23	.000*
	Religious	3.81	
Once someone has decided to commit suicide their decision can never be reversed.	Non-Religious	1.76	.887
	Religious	1.74	
People attempt suicide because of deep internal conflicts relating to their thoughts and feelings.	Non-Religious	3.81	.309
	Religious	3.93	
People attempt suicide because they are seeking revenge for wrongs done to them by others.	Non-Religious	2.00	.000*
	Religious	2.50	
People attempt suicide because they are being punished by a higher power.	Non-Religious	1.27	.000*
	Religious	1.61	

Table 2.7. Independent samples t-test for attitudes toward suicide

*Note: * indicates a significant mean difference.*

An independent samples t-test found that NRG were significantly more likely to hold the view that suicide is an acceptable means of ending one's life t (176.97) = 4.47, $p < .001$. Non-religious participants were also significantly more likely to argue that it can be justified t (200) = -4.72, $p < .001$. Religious participants were significantly more likely to feel that suicidal people can be helped t (137.16) = -3.74, $p < .001$. Religious participants were significantly

more likely to hold the view that suicide is a form of seeking revenge t (223) = -3.67, $p < .001$. Religious participants were significantly more likely to hold the view that attempting suicide is punishment by a higher power t (207.88) = -3.60, $p < .001$. Both groups view suicide as due to deep internal conflicts t (223) = -1.02, $p = .309$; and both disagree that the decision can never be reversed t (223) = .14, $p = .887$.

2.4.4.6. Spirituality

An Independent Samples t-test was conducted to test whether there was any significant difference between religious and non-religious participants in levels of spirituality. A new variable was derived called 'TotalSpiritual'.

On average spiritual participants held a significantly stronger sense of spirituality than non-religious participant's t (219) = -14.48, $p < .001$). A one-way ANOVA revealed that this difference was significant between groups F (4, 216) = 54.960, $p < .001$. A post hoc Tukey test showed that non-religious and atheist participants do not differ from each other ($p = .536$), but differ from all other religious groups ($p < .001$). All religious groups do not differ from each other in their overall level of spirituality (see appendix L for detailed output).

2.5. Discussion

Overall, it was found that religious people have a tendency to be more depressed and are likely to experience more suicidal thoughts than non-religious people, as seen in research question 1. The association between mood and cognitive components of suicide is well established within the literature (Crane et al., 2013; Isometsa, Sund & Pirkola, 2014); however, what is surprising is that, principally the literature suggests that religion is protective

against suicide and depression (Cook, 2014). Specifically, that religious beliefs act as a protective factor against negative emotional experiences (Laudet, Morgen & White, 2006) in terms of affording the sufferer hope about the future (Osafo, Knizek, Hjelmeland, & Akotia, 2013).

Nevertheless, religion and spirituality are complex paradigms (Khalaf et al., 2014; Koenig, 2007). Research has highlighted the degree to which faiths differ in terms of religious practices and belief patterns (Cohen & Hill, 2007). For example, the pioneering work of Durkheim (1897) suggested that Catholicism had greater protective characteristics than Protestantism due to stronger integration and regulation of structures and sanctions; whilst other studies have suggested that Islam is the most protective faith (Sabry & Vohra, 2013). Yet, the findings from this study show that it is not holding religious beliefs per se (Christian, Hindu, etc), but having a stronger sense of R/S that is the most important issue (Moreira-Almeida, Koenig & Luchetti, 2014). This supports the literature which proposes that religious affiliation alone cannot predict or protect against suicidality (Lawrence, Oquendo & Stanley, 2016),

Evidence strongly suggests that religion can have negative influence (Pargament, 1997); for example, religious experiences could be considered a symptom of psychosis and studies have shown that religion can have negative impact (Grover, Davuluri & Chakrbarti, 2014). So, R/S per se, are more significant influences than individual religions or specific spiritual belief patterns (Lawrence, Oquendo & Stanley, 2016), and the stronger these are, the more potentially damaging they might be. However, previous literature proposes that, the qualities that define R/S have many advantages (Koenig *et al.,* 2001). In examining individual constructs of R/S, this study hoped to obtain

a more in-depth understanding of differences between groups and test the relationship between religiosity and suicidality. The study found a counter-intuitive outcome; religious people had higher levels of depression and suicidal thoughts, despite showing higher levels of religious attachment, coping, support, forgiveness, values and spirituality, which are all considered protective forces (Capaldi, Dopko & Zelenski, 2014; Koenig *et al.,* 2001; Lawerence, Oquendo & Stanley, 2016; Lizardi et al., 2007). Why then are these supporting elements seemingly making worshipers more depressed and suicidal?

The findings of this study show that there are a number of key aspects within R/S that seem to be having a negative impact. Specifically, it was found that religion places a significant level of negative consequences on people in terms of, demands and criticism; perceptions of God as punishing and that stressful situations are a form of punishment; God as abandoning in times of need; ruminating on mistakes in relation to religious teachings; belief that past mistakes cannot be forgiven or atoned; beliefs of failing to live the 'right kind of life'.

It could be, that whilst the mechanisms of religiosity can afford all sorts of benefits, some spiritual beliefs, irrespective of a person's religious conviction, can act as a powerful negative force. This may significantly undermine a person's resilience to depression, as well as attempts to cope with psychological distress and suicidal thoughts. This is important to highlight given the research which suggests religious coping is a protective factor against suicidality (Capaldi, Dopko & Zelenski, 2014; Lawerence, Oquendo & Stanley, 2016). Here it can be seen that negative religious coping appears to

be more influential (Pargament, Smith, Koenig, & Perez, 1998); especially if beliefs are associated with a negative view of God. Therefore, it could be hypothesised, if an individual's life is organised around the existence of a higher spiritual being, perhaps God, and they hold the belief that this higher being is abandoning or punishing, the impact could be devastating. Additionally, this study found that religious participants were more likely to view suicide as a form of punishment and revenge from a higher power, therefore it may be unsurprising that religious participants were found to be significantly more suicidal and depressed.

Furthermore, it was found that religious participants more often felt they had 'failed to live the right kind of life'. Research suggests that religious individuals place higher expectations and standards on themselves (Exline, 2002) which could increase the risk of suicidality. It may be that living the 'right kind of life' is externally derived and determined for religious people, therefore not meeting the standard could explain people's views of God as punishing and higher levels of suicidal thoughts and depression. Religious participants were also found to more likely believe they can't make up for the mistakes in the past, which suggests that feelings of religiosity may not always be about a sense of forgiveness, especially of oneself. If people felt they were unable to be forgiven, this may lead to extra guilt which has shown a strong relationship with suicidality (Koenig, 2007).

Finally, whilst religious communities can act as a supportive social network (Lawerence, Oquendo & Stanley, 2016), they can also be negative, critical and condemning in ways which can be harmful over a long period of time. Thus,

generating their own domains of stress and anxiety which can impact negatively on those vulnerable to depression.

2.5.1. Implications of the Research

It is concerning that religious participants in this study were found to hold more suicidal beliefs and be more depressed; especially given the statistics showing that a high prevalence of people who commit suicide are not in contact with mental health services (Hewlett & Horner, 2015). It is important when considering mental health policy and primary prevention strategies, that religious individuals are adequately supported. Clearly the view that religion is protective can no longer be accepted at face value. This study has some important implications.

Many religions interpret God in both positive and negative terms (Stilton, Flannelly, Galek & Ellison, 2014); religious leaders need to be more aware of the harmful impact negative interpretations may have on individual's psychological health. Spiritual practices have shown to be beneficial (i.e. mindfulness) (Kabat-Zinn, 2003; Hefti, 2011), perhaps religious beliefs need to be more influenced by spiritual practices and incorporate these into religious practices. Collectively, religions may also need to change over time (i.e. Old to New Testament; from old vengeful God to a more forgiving God) in line with changes in societal issues. Engaging religious professionals with mental health policy and practice would be essential in overcoming and managing many issues surrounding mental health stigma, as well as providing more established access to mental health services.

Religious communities are in fact social network and operate the same as any society (Everton, 2015); individual difference, conflicts, confused messages,

demands, criticism and pressures can all lead to anxiety and stress in the same way as other social demands can. Religious communities need to engage in mental health awareness, and become attentive to the needs of individuals. Professionals and policy makers need to support religious communities in developing and improving mental health literacy skills.

Professionals need to consider the importance and value of R/S in an individual's life and explore how this might be both helpful and unhelpful. Professionals may not feel confident in doing this and support from managers, clinical services and professional bodies need to consider working practices and current collaborations with religious professionals and how to enhance these. Specifically, services could audit how many people currently accessing services hold religious beliefs and what direct provision for religious/spiritual care there currently is. Furthermore, professional bodies need to consider how R/S is incorporated into training; professionals may not understand or feel confident in how to ask or challenge religious beliefs and values, especially when it is in the form of negative coping or support. Further training in R/S should be available and a key element of professional training.

2.5.2. Research Limitations and Future Directions

A number of research limitations must be highlighted. Firstly, there is a clear disparity in the representativeness of all religious groups. Recruitment from certain groups was more difficult than others; this may have been due to access to participants as well as external social factors i.e. current political and social unrest dissuading people to participate, given the nature of the topic. A larger more representative sample would allow the study to draw more firm conclusions regarding how religiosity plays a role.

Secondly, participants in this study had higher education levels than what might be expected in the general population; this may bias the data in regards to how participants view topics surrounding suicide and religion. Furthermore, recruitment largely was conducted within local NHS organisations, and Universities where it could be argued that participants are less likely to hold strong religious values. Attempts to recruit from religious organisations were made, however many organisations did not want to take part due to the nature of the topic and possibly due to 'cold calling'.

Despite the low numbers, the study yielded a vast amount of data. Further analysis using this data could be conducted, where data is transformed and trimmed, to answer some questions raised by this study; however, these questions were not the principal aim of the study. Analysis exploring the interplay between negative religious coping and other elements of religiosity and its relationship with suicide may provide a useful model for understanding coping mechanisms. Furthermore, the cross-sectional design precludes any causal explanations of the results. The present study can only determine differences aspects of R/S in relation to suicidality.

Building on the current study, future research could specifically examine the interplay and relationship between forgiveness/hopelessness and suicidality in religious participants. Also understanding how religious participants use coping strategies to manage suicidal thoughts and beliefs. Alternatively, future research could specifically explore the relationship between religiosity and religious people who have attempted suicide. This may highlight important aspects the relationship between factors of religiosity and suicidality.

2.6. Conclusion

The current study aimed to understand if religiosity and spirituality influence suicidality amongst faith and non-faith communities. It was found that religious people were more likely to hold suicidal beliefs and be more depressed, contrary to the majority of literature. Furthermore, this study supports the notion that it is not specific belief systems per se that are important, but a more complex interplay between factors of religiosity/spirituality and suicidality. The findings support the proposal that negative religious coping is a significant risk factor in suicidality. This is especially important as religiosity has traditionally been viewed to be protective. Religious leaders and communities need to engage with mental health awareness and literacy to re-establish protective factors which have historically been associated with religion. Future research needs to build a model to understand how negative religious coping and other factors of religiosity specifically mediates or moderate the relationship with suicidality.

2.7. References

Abdel-Khalek, A. (2004). Neither altruistic suicide, nor terrorism but martyrdom: A Muslim perspective. *Archives of Suicide Research, 8*(1), 99–113. doi:10.1080/13811110490243840

Amitai, M., & Apter, A. (2012). Social Aspects of Suicidal Behavior and Prevention in Early Life: A Review. *International Journal Of Environmental Research And Public Health*, *9*(12), 985-994. http://dx.doi.org/10.3390/ijerph9030985

Barzilay, S., & Apter, A. (2014). Psychological Models of Suicide. *Archives of Suicide Research*, *18*(4), 295-312. http://dx.doi.org/10.1080/13811118.2013.824825

Beck, A. T., Brown, G., & Steer, R. A. (1989). Prediction of eventual suicide in psychiatric inpatients by clinical ratings of hopelessness. *Journal of consulting and clinical psychology*, *57*(2), 309.

Behere, P. B., Das, A., Yadav, R., & Behere, A. P. (2013). Religion and mental health. *Indian Journal of Psychiatry*, *55*(2), S187–S194. http://doi.org/10.4103/0019-5545.105526

Bhugra, D. (2010). Commentary: Religion, religious attitudes and suicide. *International Journal Of Epidemiology*, *39*(6), 1496-1498. http://dx.doi.org/10.1093/ije/dyq232

Bhui, K. S., Dinos, S., & McKenzie, K. (2012). Ethnicity and its influence on suicide rates and risk. *Ethnicity & health*, *17*(1-2), 141-148

Boehnlein, J. K. (Ed.). (2008). *Psychiatry and religion: The convergence of mind and spirit*. American Psychiatric Pub.

British Psychological Society. (2010). Code of Human Research Ethics. Leicester: *British Psychological Society*. http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Capaldi, C., Dopko, R., & Zelenski, J. (2014). The relationship between nature connectedness and happiness: a meta-analysis. *Frontiers In Psychology*, *5*. http://dx.doi.org/10.3389/fpsyg.2014.00976

Cohen, A. B., & Hill, P. C. (2007). Religion as culture: Religious individualism and collectivism among American Catholics, Jews, and Protestants. *Journal of Personality*, *75*(4), 709-742.

Cook, C. C. (2014). Suicide and religion. *British Journal of Psychiatry,* 204(4), 254-255. DOI: 10.1192/bjp.bp.113.136069

Crane, C., Barnhofer, T., Duggan, D.S., Eames, C., Hepburn, S., Shah, D & Williams, J.M.G. (2013). Comfort from suicidal cognition in recurrently depressed patients. *Journal of Affective Disorders*. http://dx.doi.org/10.1016/j.jad.2013.11.006i

Daniel, S. S., Goldston, D. B., Erkanli, A., Franklin, J. C., & Mayfield, A. M. (2009). Trait Anger, Anger Expression, and Suicide Attempts among Adolescents and Young Adults: A Prospective Study. *Journal of Clinical Child and Adolescent Psychology : The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, 38(5), 661–671.

Dervic, K., Oquendo, M. A., Grunebaum, M. F., Ellis, S., Burke, A. K., & Mann, J. J. (2004). Religious affiliation and suicide attempt. *The American Journal of Psychiatry, 161*(12), 2303–2308. doi:10.1176/appi.ajp.161.12.2303

Durkheim, E. (1966 [1897]). Suicide: A Study in Sociology. New York: Free Press.

Everton, S.F. (2015). Networks and Religion: Ties that Bind, Loose, Build Up and Tear Down. *Journal of Social Structure,* 16. Retreived from https://www.cmu.edu/joss/content/articles/volume16/Everton.pdf

Exline, J. (2002). Stumbling Blocks on the Religious Road: Fractured Relationships, Nagging Vices, and the Inner Struggle to Believe. *Psychological Inquiry, 13*(3), 182-189. Retrieved from http://www.jstor.org/stable/1449327

Fisher, J. (2011). The Four Domains Mode: Connecting Spirituality, Health and Well-Being. *Religions,* 2, 17-28, doi:10.3390/rel2010017

Giegling, I., Olgiati, P., Hartmann, A.M., Calati, R., Moller, H.J., Rujescu, D. & Serretti, A. (2009). Personality and attempted suicide. Analysis of aggression and impulsivity. *Journal of Psychiatric Research,* 43(16), 1261-71.

Griffith, E. E., & Bell, C. C. (1989). Recent trends in suicide and homicide among blacks. *Jama*, *262*(16), 2265-2269.

Grover, S., Davuluri, T., & Chakrabarti, S. (2014). Religion, Spirituality, and Schizophrenia: A Review. *Indian Journal of Psychological Medicine*, *36*(2), 119–124. http://doi.org/10.4103/0253-7176.130962

Hall, D. E., Meador, K. G., & Koenig, H. G. (2008). Measuring religiousness in health research: Review and critique. *Journal of religion and health*, *47*(2), 134-163.

Harrison, V. (2006). The pragmatics of defining religion in a multi-cultural world. *International Journal For Philosophy Of Religion*, *59*(3), 133-152. http://dx.doi.org/10.1007/s11153-006-6961-z

Hefti, R. (2011). Integrating Religion and Spirituality into Mental Health Care, Psychiatry and Psychotherapy. *Religions*, *2*(4), 611-627. http://dx.doi.org/10.3390/rel2040611

Hewlett, E. & Horner, K. (2015). Mental Health Analysis Profiles: OECD Working Paper No. 81. Available at: http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2015)4&docLanguage=En

Ineichen, B. (1998). The influence of religion on the suicide rate: Islam and Hinduism compared, *Mental Health, Religion & Culture*, 1(1), 31-36, DOI: 10.1080/13674679808406495

International Association for Suicide Prevention. (2015). Facts About Suicide. (2015). *International Association for Suicide Prevention*. [online] Available at: https://www.iasp.info/ [Accessed 9 Sep. 2016].

Isometsä, E., Sund, R., & Pirkola, S. (2014). Post-discharge suicides of inpatients with bipolar disorder in Finland. *Bipolar Disorders*, *16*(8), 867-874. doi:10.1111/bdi.12237

Kabat-Zinn, J. (2003), Mindfulness-Based Interventions in Context: Past, Present, and Future. Clinical Psychology: *Science and Practice*, 10: 144–156. doi:10.1093/clipsy.bpg016

Khalaf, D., Hlais, S., Haddad, R., Mansour, C., Pelissolo, A., & Naja, W. (2014). Developing and testing an original Arabic religiosity scale. Middle East Current Psychiatry, 21(2), 127–138.

Koenig, H.G. (2007). Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. J Nerv Ment Dis 195:389-395.

Koenig, H.B., McCullough, M.E. & Larson, D.B. (2001). Handbook of religion and health. Oxford: Oxford University Press.

Laudet, A. B., Morgen, K., & White, W. L. (2006). The Role of Social Supports, Spirituality, Religiousness, Life Meaning and Affiliation with 12-Step Fellowships in Quality of Life Satisfaction Among Individuals in Recovery from Alcohol and Drug Problems. *Alcoholism Treatment Quarterly*, *24*(1-2), 33–73. http://doi.org/10.1300/J020v24n01_04

Lawrence, R., Oquendo, M., & Stanley, B. (2016). Religion and Suicide Risk: A Systematic Review. *Archives Of Suicide Research*, *20*(1), 1-21. http://dx.doi.org/10.1080/13811118.2015.1004494

Lizardi D, Currier D, Galfalvy H, Sher L, Burk A, & Mann J. (2007). Perceived reasons for living at index hospitalization and future suicide attempt. Journal of Nervous and Mental Disease. 195:451–455.

Loewenthal, K.M., MacLeod, A.K, Goldblatt, V. et al. (2000). Comfort and joy: Religion, cognition and mood in individuals under stress. *Cognition and Emotion*, 14, 355–374.

McLean, J., Maxwell, M., Platt, S., Harris, F. M., & Jepson, R. (2008). Risk and protective factors for suicide and suicidal behaviour: A literature review. *Scottish Government.*

Moreira-Almeida, A., Neto, F. L., & Koenig, H. G. (2006). Religiousness and mental health: a review. *Rev Bras Psiquiatr, 28*(3), 242-250.

Moreira-Almeida, A., Koenig, H., & Lucchetti, G. (2014). Clinical implications of spirituality to mental health: review of evidence and practical guidelines. *Revista Brasileira De Psiquiatria*, *36*(2), 176-182. http://dx.doi.org/10.1590/1516-4446-2013-1255

Nkansah-Amankra, S., Diedhiou, A., Agbanu, S.K., Abganu, H.L.K, Opoku-Adomako, N.S. & Twumasi-Ankrah, P. (2012). A Longitudinal evaluation of religiosity and psychosocial determinants of suicidal behaviours among a population-based sample in the United States. *J. Affect. Dis.* 139, 40-51.

Nock, M., Park, J., Finn, C., Deliberto, T., Dour, H., & Banaji, M. (2010). Measuring the Suicidal Mind. *Psychological Science*, *21*(4), 511-517. http://dx.doi.org/10.1177/0956797610364762

Osafo, J., Knizek, B. L., Akotia, C. S., & Hjelmeland, H. (2013). Influence of religious factors on attitudes towards suicidal behaviour in Ghana. *Journal of religion and health*, *52*(2), 488-504.

Pargament, K. I. (1997). The psychology of religion and coping: Theory, practice and research. *New York: Guilford*.

Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the scientific study of religion*, 710-724.

Sabry, W. M., & Vohra, A. (2013). Role of Islam in the management of Psychiatric disorders. *Indian Journal of Psychiatry*, *55*(Suppl 2), S205–S214. http://doi.org/10.4103/0019-5545.105534

Silton, N.R., Flannelly, K.J., Galek, K. (2014). Beliefs About God and Mental Health Among American Adults. *Journal of Religion and Health,* 53, 1285-1296 doi:10.1007/s10943-013-9712-3

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S., Selby, E. A., & Joiner, T. E. (2010). The Interpersonal Theory of Suicide. *Psychological Review*, *117*(2), 575–600. http://doi.org/10.1037/a0018697

You, S., Van Orden, K. A., & Conner, K. R. (2011). Social connections and suicidal thoughts and behavior. *Psychology of Addictive Behaviors*, *25*(1), 180.

Van Praag HM. The role of religion in suicide prevention. In: Wasserman D, Wasserman C, (2009). editors. Oxford Textbook of Suicidology and Suicide Prevention. Oxford: Oxford University Press. p. 7-12.

Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. American Psychological Association.

World Health Organization . (2013a). *Mental health action plan, 2013-2020*. Retrieved from apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf

World Health Organization . (2013b). *Preventing suicide: A resource for suicide case registration*. Geneva, Switzerland: Author.

Zhao, J., Yang, X., Xiao, R., Zhang, X., Aguilera, D., & Zhao, J. (2012). Belief system, meaningfulness, and psychopathology associated with suicidality among Chinese college students: a cross-sectional survey. *BMC public health*, *12*(1), 668.

Chapter 3: Reflective Paper

Religion, Research and Psychology: A Reflective Account

Chapter Word Count: 3202

(excluding quotes and references)

3.1. Introduction

Where I began to learn about reflection came from an extract in the Harry Potter novel "The Goblet of Fire" where Dumbledore comments on his use of the Penseive.

> *"At these times" said Dumbledore, indicating the stone basin, "I use the Penseive. One simply siphons the excess thoughts from one's mind, pours them into a basin, and examines them at one's leisure. It becomes easier to spot patterns and links, you understand, when they are in this form."*
>
> (Rowling, 2000; p. 519)

This is a rudimentary description of what can be described as taking a step back to notice our thoughts and reflecting and was my first interaction with reflection. However, reflection goes further and can be understood as the conscious weighing and integration of our perspectives, experiences, thoughts and feelings (Boenik *et al.,* 2004). We may not have a magic stone basin in which to extract our thoughts, but reflecting through processes can be done in many ways and is essential to personal development (Helyer, 2015).

This paper will focus on my journey through the process of developing as a doctoral level researcher. With clinical psychology training including the assimilation and accommodation of a variety of concepts and skills across both academic and clinical practice, reflection became crucial to understanding the different roles that I currently occupy; that of a Hindu, a trainee, a clinician, a researcher, and the ability to integrate and understand the impact of these roles on me and my journey.

Lavender (2003) suggests that reflective practice includes: (1) Reflection-in-action, (2) Reflection-on-action, (3) Reflection about your impact on others, and (4) Reflection on the relationship between the work and the self. I feel this model fits with the complex framework in which clinical psychologists are trained. We work across a variety of settings, as both clinicians and academics, but also beyond this, focussing on our individual identities as people. I believe Lavender's model allows me to explore my development as a researcher as well an individual. I will use this to explore areas of my journey through research.

3.2. Choosing a Research Topic

The first challenge was choosing a topic. Initially, I was sure I would do a project involving children and young people, in line with my clinical interests; but choosing a topic was difficult as I had so many interests. I approached supervisors and followed the guidance on choosing a topic, but I still struggled to settle on a research idea. I got stuck in a 'push and pull' relationship with topics, finding reasons to both follow and discard them.

Using my reflective log, one particular theme that had become evident was the difficulties in my own life surrounding identity, isolation, and mental health. What struck me was why I had never talked to any professional about my own feelings of low mood. I had not initially considered this an area for research, more an area of personal development. When reflecting on this further, I noticed similar patterns in my life where family would not discuss psychological distress. I considered how mental health was still such a big taboo within the Indian community (Time to Change, 2010) and reflected my own experiences of avoidance of the topic.

This was further highlighted during a mental health awareness event at a Hindu temple, where I was approached by a religious lady (*pseudonym* Mary), who wanted to discuss her own experiences of mental health and suicidal ideation. Despite approaching me, she was hesitant of the topic, often avoiding direct discussion of suicide, externalising it and not fully engaging with the discussion. What struck the most was that Hindu teachings actively refer to and is positive the mind-body duality, so why did I, and others avoid such topics? The temple itself was promoting mental health as part of a bigger health programme, but few people attending the mental health area.

As part of the event, I had explored research examining ethnicity, religion and mental health. I found that factors relating to social support within religious groups was considered protective (Koenig *et al.,* 2001) and the advantage British Indian children have in mental health (Goodman, Patel, Leon, 2010). Yet more often than not people from minority groups do not openly talk about the impact of mental health (Keynejad, 2008). So if people don't talk about it, how can social support be protective? I revisited Hindu teachings which promote mind-body harmony and considered what role religion had to play and whether it was in fact protective. There is extensive research on religion and mental health (Moreira-Almeida, Neto & Koenig, 2006) and I decided to approach my supervisor to discuss developing a project from this. I was keen to explore this area, so began to formulate some questions to explore the viability of this topic.

3.3.1. Developing the Research

Becoming more familiar with religion and mental health, I was surprised at the vast amount of research that had been conducted in this area. From personal

experiences, what became evident was that suicide appeared to be more of a taboo than depression or anxiety within the Indian community. From a Hindu perspective, suicide is condoned within scriptures (Kang, 2010), so perhaps it was unsurprising that Mary felt conflicted about discussing her suicidal ideations. This guided the project to explore religion and suicide. More specifically, I became particularly interested in, what it was about religion that helped or hindered people. Partly this dichotomy reflected my own difficulties; in particular, feeling abandoned at times and wondering 'what the bigger picture was'. But also how religious people view suicide.

Both religion and suicide are extremely complex constructs which are difficult to measure (Khalaf et al., 2014); this initially drew me to qualitative research I felt it would give me to opportunity to fully explore people's views. I also wondered if this was partly a way of me getting answers for myself; knowing how others use religion to cope. However, I was uncertain as to whether people would want to engage with this topic. I also questioned whether this topic would be too close to home and a suitable topic. It could be argued that, just as clinical practice involves an element of the Self (Aponte, 1992) so does research. Qualitative research often involves the concept of an 'insider' position within research (Berger, 2015). Here the researcher's connection and familiarity with a topic can be beneficial by utilising the researcher's knowledge and experience to guide the project and possibly increase engagement within groups (i.e. more likely to recruit Hindu participants, being a Hindu). However, it is essential to be mindful of the limitations and biases this can also bring such as being blind to failures and being enmeshed with the emotions that arise within the research (i.e. distress).

Furthermore, at time same time, difficulties in my personal life whereby people I knew were experiencing similar thoughts made me hesitant to engage at such a ‘deep’ level. Even without direct personal experience of suicide, I was aware it is a highly emotive topic. I was mindful of becoming enmeshed in the powerful emotions associated with suicide; especially that of hopelessness. The vastness of the subject of suicidality and religion was daunting. I was also conscious of an internal conflict between religion, mental health, and coping styles. Specifically, I observed that I was struggling to draw on positive coping resources from my own faith. I was ambivalent when approaching these topics; and with ambivalence came uncertainty about the research process and I began to disengage with the topic. This significantly pushed the research timeline back leaving me with more stress and pressure.

Although I was keen to pursue qualitative research, I was aware of the importance to maintain some degree of separation from my research. It became apparent using quantitative methods was the more sensible option; this not only allowed me to distant myself from the subject, but also allowed me to use my previous knowledge and experience of quantitative research methodology. I considered whether quantitative methodology was just another form of avoidance from engaging with a topic, however, self-care became paramount as multiple stressors from both the course and my personal life were growing. Moreover, I was drawn to the positive epistemological position that quantitative research offered, in order to search for meaning and understanding in regards to religion and its role in suicide and mental health.

3.3.2. Challenges in the Process

The setback of me avoiding my research and my own difficulties became evident in my final year. The bulk of my research was still outstanding. I became frustrated with myself, and I compared myself to my peers who seemed to be far ahead. This was an unusual experience as I typically would not compare myself to peers; this brought with it feelings of resentment toward others, but also a critical self. I noticed myself detaching from my peers, and having more ruptures in the relationship with my research, specifically that I did not like it. I had become so detached from my research that the study became overwhelming and I spent countless hours worrying. I knew my research would not reach its full potential in the limited time I had left myself and began to worry about failing the course. Through supervision, I realised this was a repeating pattern, similar to my masters' research. A key element became to repair my relationship with the research by immersing myself in the literature.

With the complexity of the topics, I noticed my struggle to understand religiosity and spirituality, both in terms of theoretical explanations, but also from a personal perspective. This was not helped by the avoidance of engaging with the research until such a late stage. Even after writing the thesis, seeing the outcomes, numerous discussions with my supervisor and with others who have supported me, I wonder if I truly understand the concept. This was reflected in the amount of times I re-wrote the papers and constantly searched for more information. I wondered if I had a good grasp of the topic. Part of my personal conflict with the research related to the concept of measuring religiosity; to try and psychometrically justify someone's level of religiousness

felt too ambiguous. This was also fuelled by the lack of consensus and guidance in the literature of how to do this. I considered what it meant to be religious and how this might shift through time and events. For me, being religious did not mean regularly attending a place of worship, or actively doing things for my religion; but was more related to how I view the world. Drawing on personal experience, I noticed my own levels of religiosity shift as events unfolded in my life. I wondered if this was why people did not engage with the project as they also struggled to grasp the concepts within the research.

A particular difficulty arose with recruitment of participants. Despite a lot of work to advertise the research and support of many people in promoting it, there were problems in recruiting a representative sample. This became frustrating and a big concern in regards to how good the project would be. However, it was not recruitment per se that caused my frustration, but more that it highlighted issues that began the project i.e. that minority groups don't openly talk about mental health and suicide. Whenever I directly approached and discussed the research with people from all faith groups, I generally got a positive response; however, this engagement almost appeared to be superficial which left me feeling lost. Beyond having more time, I felt powerless and useless in doing more to recruit participants. In part, this felt uncomfortable as participants had the information I needed, whereas normally, people would come and see me in my clinical role to discuss issues around suicide and mental health. It also left me feeling a failure not being able to recruit the groups I needed. Learning from this in the future, I need to be mindful of my relationship and engagement with topics which are close to home.

3.4. Researcher vs Clinician

A key aspect of the doctorate at Coventry has been to develop trainees to be well rounded clinicians and academics. When I began the course, I did not consider myself an academic, despite people frequently commenting that I must be as I am doing a doctorate; instead I believed the course to simply be practical training to becoming a clinician. Overcoming the view that I was training to be purely a clinician was crucial to engaging with the research process. This has somewhat shifted to have a different conceptualisation of what an academic is. Instead of someone who is purely teaching or specialising in research in a given field, being an academic has involved applying knowledge and skills into practice and vice versa taking clinical skills and applying it to my research.

Firstly, it is important for any researcher to be aware of their reasons for doing research. The topic of religion and mental health is one that has been extremely prevalent to me over the last few years. As the research process developed, I realised that this research was as much about my own relationship with mental health and religion, as it was about the people I help through my clinical work.

Secondly, training in clinical psychology and research is not an either/or option, but a harmony between the two. Beyond the course requirements, I realised that research was an opportunity to understand a topic from the lens of an academic. As clinicians, we frequently use theory and research to inform our clinical work, so this became an opportunity to understand a topic in depth and contribute to a field. My development as a researcher has changed through the process of training; the journey has highlighted my desire to explore many

avenues and understand them in-depth, but often at the risk of getting carried away. I have learnt to become more accepting of my limitations as well as research limitations. A key learning element for both aspects of myself the researcher and clinician, is being aware of my relationship and engagement with topics; especially those that lead to ambivalence and avoidance.

At times I found it difficult to juggle the two roles, researcher versus clinician, especially with such a sensitive topic. I worried whether the topic would also be emotive to participants and would not get a high response rate. My clinical-self wanted to be able to offer personal support to those engaging in the research, especially as that people who engage in research are more likely to do so out of personal interest/experience. As an online anonymous survey, this was clearly not an option, but also I wondered whether my inclination to offer support was more due to worry about being a responsible clinician.

Through the research journey I have applied clinical skills to the research process. Specifically, viewing the research in terms of a therapeutic relationship was helpful to know when things were going wrong and when my engagement changed i.e. being attuned to my feelings toward the research. This was essential throughout the research process, from choosing a topic, to refining the idea and even writing the thesis.

3.5. Personal and Professional Development

My experiences through the course have given me more than just the ability to hone my clinical skills and apply theory into practice; for me this journey has been one of self-knowledge and learning. It has highlighted the importance of knowing myself in line with psychodynamic teaching, however as I develop a

sense of my professional identity and integrate this with my personal identity I have questioned my position as a psychologist and raised questions of when therapy does not work. I have grown more confident in my skills and abilities but my biggest learning has been through developing my identity and its role in my development as a clinician and academic.

During my teaching in Cognitive Analytic Therapy (CAT) I began to understand how people work in relational patterns. Similarly, developmental psychology focuses on individuals move from dependence as a child to independence as an adult and how we build patterns of relationships, in contrast, eastern culture and values holds the view that humans move toward connection. The notion of a cross-cultural therapist (Rajan, 2012) has been a key learning aspect; drawing on skills as both an individual and as a professional to develop my research interests has been surprising. I had not considered my personal self within my professional role, however can clearly see the influence within my research.

Choosing a research topic which was very personal at times was difficult; I required a lot of support to overcome difficulties which hindered my ability to engage with this research and impacted on my development as a researcher. Looking inward has been a challenging but useful, and has made me consider the notion of reflection from the Harry Potter novel. If we could in fact extract our thoughts, it may be easier to detach and examine them, nonetheless it is clearly an important aspect for self-development. I would be negligent if I was to believe I had reached self-awareness as this is continuously a fluctuating concept; but since the beginning of the course I have noticed myself grow in

confidence in my skills, abilities and knowledge and better understand my reasons for becoming a psychologist.

For me, the biggest shift has been in recognising that mental health can affect anyone; it is a spectrum which is individual to the person and recognising my own position within this is crucial to knowing my own limits and blind spots. I have particularly noticed that I often hold black and white views regarding certain topics, and hold assumptions which may interfere with my own learning and impact on my work.

3.6. The Future

The pressures beyond training may be different to that of a trainee, however this experience has highlighted the importance of developing my identity and having skills to utilise myself. I can also appreciate that self-awareness is an on-going process which is continuously influenced by our current circumstances. I must remain mindful of how I adjust during difficult times and develop a clearly picture of what my coping strategies are. It is often believed that medical professionals do not need the same support as those accessing their services however as with all people, support is often needed. Taking forward my skills from training and maintaining some link with my trainee life will be crucial during my work as a qualified psychologist. The journey of personal and professional development is one that psychologists need to continue (Cheshire, 2000); although the personal element appears to be less emphasised.

The research process specifically has highlighted both strengths and weaknesses; addressing these have not been easy, which require on-going

work, including knowing my blind spots. But I have a clearer picture of my role as a researcher. Research is clearly an important skill within a psychologist's repertoire, especially when utilising these skills within services, although, it is important to hold in mind the role and ability to differentiate between clinical work and research work. I chose a topic and design which had large element of the self. My systematic review has given me more grounding on professional practice and my role as a Hindu, whereas my empirical has been more of a personal journey of discovery in coping. I will take both of these forward into my future career.

3.7. References

Aponte, H. J. (1992). Training the person of the therapist in structural family therapy. Journal of Marital and Family Therapy, 18(3), 269-281. doi: 10.1111/j.1752-0606.1992.tb00940.x

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research,* 15(2), 219-234. doi: 10.1177/1468794112468475

Boenink A.D., Oderwald A.K, deJonge P., vanTilburg W. and Smal J.A. (2004). Assessing student reflection in Medical Practice. *Medical Education*, 38, 368 – 377.

Cheshire, K.E. (2000). Professional Socialization in Clinical Psychology Trainees (Unpublished PhD Thesis). University of Liverpool, Liverpool, England.

Goodman, A., Patel, V., & Leon, D. A. (2010). Why do British Indian children have an apparent mental health advantage?. *Journal of Child Psychology and Psychiatry*, *51*(10), 1171-1183.

Helyer, R. (2015). Learning through reflection: the critical role of reflection in work-based learning (WBL), *Journal of Work-Applied Management*, 7(1), 15-27, doi: 10.1108/JWAM-10-2015-003

Kang, C. (2010). Hinduism and Mental Health: engaging British Hindus, Mental Health, Religion & Culture, 13:6, 587-593, DOI: 10.1080/13674676.2010.488427

Keynejad, R. (2008). Barriers to help seeking: What stops ethnic minorities in Redbridge accessing mental health services? *RedbridgeCVS*. Retrieved from: http://www.rcmh.org.uk/documents/reports/barrierstoseekinghelp.pdf

Khalaf, D., Hlais, S., Haddad, R., Mansour, C., Pelissolo, A., & Naja, W. (2014). Developing and testing an original Arabic religiosity scale. *Middle East Current Psychiatry,* 21(2), 127–138.

Koenig, H.B., McCullough, M.E. & Larson, D.B. (2001). Handbook of religion and health. Oxford: Oxford University Press.

Lavender, T. (2003). Redressing the balance: the place, history and the future of reflective practice in clinical training. . Clinical Psychology, 27, 11-15.

Moreira-Almeida, A., Neto, F. L., & Koenig, H. G. (2006). Religiousness and mental health: a review. *Rev Bras Psiquiatr, 28*(3), 242-250.

Rajan, A. (2012). Counselling psychologists talk about cross-cultural therapy: A thematic analysis. Retrieved from: http://roar.uel.ac.uk/3039/1/2012_DCounPsych_Rajan.pdf

Rowling, J.K. (2000). *Harry Potter and the Goblet of Fire* (1st ed.). London: Bloomsbury.

Time to Change. (2010). Family Matters: A report into attitudes toward mental health problems in the South Asian community. Retrieved from: https://www.time-to-change.org.uk/sites/default/files/imce_uploads/Family%20Matters.pdf

Appendices

Appendix A: Author Guidelines for Mental Health, Religion & Culture

Use these instructions if you are preparing a manuscript to submit to *Mental Health, Religion & Culture*. To explore our journals portfolio, visit http://www.tandfonline.com/, and for more author resources, visit our Author Services website.

Mental Health, Religion & Culture considers all manuscripts on the strict condition that

- the manuscript is your own original work, and does not duplicate any other previously published work, including your own previously published work.
- the manuscript has been submitted only to *Mental Health, Religion & Culture*; it is not under consideration or peer review or accepted for publication or in press or published elsewhere.
- the manuscript contains nothing that is abusive, defamatory, libellous, obscene, fraudulent, or illegal.

Please note that *Mental Health, Religion & Culture* uses CrossCheck™ software to screen manuscripts for unoriginal material. By submitting your manuscript to *Mental Health, Religion & Culture* you are agreeing to any necessary originality checks your manuscript may have to undergo during the peer-review and production processes.

Any author who fails to adhere to the above conditions will be charged with costs which *Mental Health, Religion & Culture* incurs for their manuscript at the discretion of *Mental Health, Religion & Culture*'s Editors and Taylor & Francis, and their manuscript will be rejected.

This journal is compliant with the Research Councils UK OA policy. Please see the licence options and embargo periods here.

Manuscript preparation

1. General guidelines

- Manuscripts are accepted in English. British English spelling and punctuation are preferred. Please use double quotation marks, except where "a quotation is 'within' a quotation". Long quotations of 40 words or more should be indented without quotation marks.
- A typical manuscript will not exceed 6000 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references;

appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

- Abstracts of 150 words are required for all manuscripts submitted. Abstracts should not include any citations or references, and should not be structured (i.e. contain headings).
- Each manuscript should have 3 to 7 keywords.
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Biographical notes on contributors are not required for this journal.
- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:
- *For single agency grants:* "This work was supported by the [Funding Agency] under Grant [number xxxx]."
- *For multiple agency grants:* "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."
- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. Style guidelines

- Description of the Journal's article style.
- Description of the Journal's reference style.
- Guide to using mathematical scripts and equations.
- Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

3. Figures

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

4. Publication charges

Submission fee

There is no submission fee for *Mental Health, Religion & Culture*.

Page charges

There are no page charges for *Mental Health, Religion & Culture*.

5. Reproduction of copyright material

- If you wish to include any material in your manuscript in which you do not hold copyright, you must obtain written permission from the copyright owner, prior to submission. Such material may be in the form of text, data, table, illustration, photograph, line drawing, audio clip, video clip, film still, and screenshot, and any supplemental material you propose to include. This applies to direct (verbatim or facsimile) reproduction as well as "derivative reproduction" (where you have

created a new figure or table which derives substantially from a copyrighted source).

- You must ensure appropriate acknowledgement is given to the permission granted to you for reuse by the copyright holder in each figure or table caption. You are solely responsible for any fees which the copyright holder may charge for reuse.
- The reproduction of short extracts of text, excluding poetry and song lyrics, for the purposes of criticism may be possible without formal permission on the basis that the quotation is reproduced accurately and full attribution is given.
- For further information and FAQs on the reproduction of copyright material, please consult our Guide.

6. Supplemental online material

Authors are encouraged to submit animations, movie files, sound files or any additional information for online publication.

Information about supplemental online material

Manuscript submission

All submissions should be made online at the *Mental Health, Religion & Culture* Scholar One Manuscripts website. New users should first create an account. Once logged on to the site, submissions should be made via the Author Centre. Online user guides and access to a helpdesk are available on this website.

Manuscripts may be submitted in any standard editable format, including Word and EndNote. These files will be automatically converted into a PDF file for the review process. LaTeX files should be converted to PDF prior to submission because ScholarOne Manuscripts is not able to convert LaTeX files into PDFs directly. All LaTeX source files should be uploaded alongside the PDF.

Click here for information regarding anonymous peer review.

Books for review should be directed to Professor Christopher Alan Lewis. For queries regarding book reviews, please contact Professor Christopher Alan Lewis at: Institute for Health, Medical Sciences and Society, Glyndwr University, Plas Coch Campus, Mold Road, Wrexham, LL11 2AW, Wales, UK. Email: ca.lewis@glyndwr.ac.uk.

Copyright and authors' rights

To assure the integrity, dissemination, and protection against copyright infringement of published articles, you will be asked to assign us, via a Publishing Agreement, the copyright in your article. Your Article is defined as the final, definitive, and citable Version of Record, and includes: (a) the

accepted manuscript in its final form, including the abstract, text, bibliography, and all accompanying tables, illustrations, data; and (b) any supplemental material hosted by Taylor & Francis. Our Publishing Agreement with you will constitute the entire agreement and the sole understanding between you and us; no amendment, addendum, or other communication will be taken into account when interpreting your and our rights and obligations under this Agreement.

Open Access

Taylor & Francis Open Select provides authors or their research sponsors and funders with the option of paying a publishing fee and thereby making an article permanently available for free online access – *open access* – immediately on publication to anyone, anywhere, at any time. This option is made available once an article has been accepted in peer review.

Last updated 27/08/2014

Appendix B: Ethical Approval (Literature Review)

Certificate of Ethical Approval

Applicant:

Lakshman Ganatra

Project Title:

The influence of religiosity / spirituality within mental health practice: a systematic review of the literature.

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

12 April 2017

Project Reference Number:

P52576

Appendix C: Quality Assessment Framework

	Baker & Wang, 2004	Blair, 2015	Crossley & Salter, 2005	Dura-Vila, Hagger, Dein & Leavey, 2011	El-Nimr, Green, Salih, 2004	Eeles, Lowe & Wellman, 2003	Foskett, Marriott & Wilson-Rudd, 2004	Gubi, 2004	Gubi, 2009	Jackson & Coyle, 2009	Martinez & Baker, 2000	McVittie & Tiliopoulous, 2007	Mir, Meer *et al.*, 2015	Needleman & King, 1993	Udell & Chandler, 2000	West, 1997	West, 1998	Wyatt, 2002
Questions for all papers																		
Does the title reflect the content?	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	1
Are the authors credible?	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Does the abstract summarize the key components?	2	2	2	2	2	2	0	1	2	2	2	2	2	2	2	2	2	1
Is the rationale for undertaking the research clearly outlined?	2	2	2	1	1	2	1	1	1	2	1	2	2	2	2	2	2	2
Is the literature review comprehensive and up-to-date?	2	1	2	1	0	2	2	0	1	2	1	1	2	1	2	2	2	2
Is the aim of the research clearly stated?	1	2	1	2	1	2	2	1	2	2	1	2	2	2	2	2	2	2
Are all ethical issues identified and addressed?	0	2	0	0	0	2	0	0	1	1	0	0	2	0	1	0	0	0
Is the methodology identified and justified?	2	2	2	2	0	2	1	1	1	2	1	2	1	1	2	2	2	2
Are the results presented in a way that is appropriate and clear?	2	2	2	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2
Is the discussion comprehensive?	2	1	2	2	1	2	2	0	2	2	1	2	2	2	2	1	1	2
Are the results generalizable?	0	0	0	0	1	0	1	1	0	0	0	0	1	2	0	0	0	0
Are the results transferable?	1	1	1	1	0	1	0	1	2	2	1	1	1	1	1	1	1	1
Is the conclusion comprehensive?	1	2	2	1	1	1	2	1	2	2	1	2	2	2	2	2	2	2
Questions for Quantitative Papers																		
Is the study design clearly identified, and is the rationale for choice of design evident?					0		1	1						1				
Is there an experimental hypothesis clearly stated?					1		1	0						0				
Is the population identified?					1		2	2						2				
Is the sample adequately described and reflective of the population?					0		2	1						2				
Is the method of data collection valid and reliable?					0		1	1						2				
Is the method of data analysis valid and reliable?					0		1	1						2				
Questions for Qualitative Papers																		
Are the philosophical background and study design identified and the rationale for choice of design evident?	1	2	2	0		0		0	1	2	0	2	1		1	2	2	2
Are the major concepts identified?	1	1	2	2		2		0	1	2	0	2	2		2	2	2	2
Is the context of the study outlined?	1	2	2	1		1		0	1	2	0	1	1		0	1	2	1
Is the selection of participants described and the sampling method identified?	1	2	2	1		2		0	1	2	1	2	2		0	2	2	2
Is the method of data collection auditable?	2	2	2	2		2		1	1	2	1	1	1		1	2	2	2
Is the method of data analysis credible and confirmable?	2	2	2	2		2		1	2	2	2	2	2		2	2	2	2
Total	27	32	32	26	15	31	25	20	26	35	19	29	32	30	28	31	32	30

Appendix D: Author Guidelines for Suicide and Life-Threatening Behavior

Submissions

As of December 1, 2010 all manuscript submissions to Suicide and Life-Threatening Behavior can be made online via Manuscript Central, the web-based submission, tracking and peer review system.

Suicide and Life-Threatening Behavior is devoted to emergent theoretical, scientific, clinical, and public health approaches related to violent, self-destructive, and life-threatening behaviors. It is multidisciplinary and concerned with a broad range of related topics including, but not limited to, suicide, suicide prevention, death, accidents, biology of suicide, epidemiology, crisis intervention, postvention with survivors, nomenclature, standards of care, clinical training and interventions, violence.

Brief Summary. Manuscripts should be submitted with a 200-word abstract. The entire manuscript, including references, quotations, text, and tables, and be double-spaced. American Psychological Association (APA) standard style should be used. Manuscript length, except under unusual circumstances, should not be over 20 double-spaced pages, and, ordinarily, should be shorter.

Original Contributions. Authors should only submit manuscripts that have not been published elsewhere, and are not under review by another publication. Cover Letter. With your submission include a cover letter designating one author as correspondent for the review process, and provide a complete address, including phone and fax. In this letter please attest that neither the manuscript nor any other substantially similar paper has been published, except as described in the letter. The corresponding author should also attest that in the case of several authors, each one has studied the manuscript in the form submitted, agreed to be cited as a coauthor, and has accepted the order of authorship. If author affiliations are given with regard to academic, hospital, or institutional affiliations, it is the author[s] responsibility to obtain any required permissions from the proper authorities to utilize such affiliations.

Editing. Manuscripts will be copyedited, and page proofs will be sent to the authors for review. Authors are responsible for all statements made in their work. Manuscripts should not only be well written in the sense of organization and clarity, but should be explained in a manner that is interesting and engaging to readers with a wide range of backgrounds. All manuscripts should begin with an abstract of the paper.

Manuscript Preparation. Your paper should be double spaced and submitted in Microsoft Word. On the title page list the full names, affiliations, and professional degrees of all the authors. Abbreviations should not be used in the title or abstract, and should be very limited in the text.

Abstracts. An abstract of up to 200 words must include the following sections and headings: Objective: a brief statement of the purpose of the study; Method: a summary of study participants (sample size, age, gender, ethnicity), and descriptions of the study design and procedures; Results: a summary of the primary findings; Conclusions: a statement regarding the implications of the findings. Below the abstract, supply up to five keywords or short phrases.

References. Reference lists should be prepared according to the style illustrated in the articles in this issue of the journal. This approach minimizes punctuation in the specific references, but utilizes the author and date in the text of the articles, to provide maximum information quickly to the reader.

Illustrations. Graphics should be executed in Microsoft Excel in either Mac or IBM formats for making graphs. If this is not possible, please submit camera ready copy. In all cases indicate the correct positioning of the item in the text. Illustrations should be cited in order in the text using Arabic numerals. A legend should accompany each illustration, and not exceed 40 words. Please include reproductions of all illustrations. As the author you are ultimately responsible for any required permissions regarding material quoted in your text, tables, or illustrations of any kind.

Tables. Tables should be cited in order in the text using Arabic numerals. Each table should be displayed on a separate page, and each must have a title.

Reviews and Decisions. Manuscripts are generally sent to outside reviewers, and you will be informed of the editorial decision as soon as possible. Ordinarily a decision will be reached in about 3 months after submission is acknowledged. A request for revising the manuscript along the lines suggested by the Editor and reviewers does not constitute a decision to publish. All revised manuscripts will be re-evaluated, and the Editors reserve the right to reject a paper at any point during the revision process.

Author Services. Free access to the final PDF offprint or your article will be available via author services only. Please therefore sign up for author services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Visit http://authorservices.wiley.com/bauthor/ to sign up for author services.

Copyright Transfer Agreement

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions https://authorservices.wiley.com/author-resources/Journal-Authors/licensing-open-access/licensing/licensing-info-faqs.html

For authors choosing OnlineOpen

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

- Creative Commons Attribution License OAA
- Creative Commons Attribution Non-Commercial License OAA
- Creative Commons Attribution Non-Commercial -NoDerivs License OAA

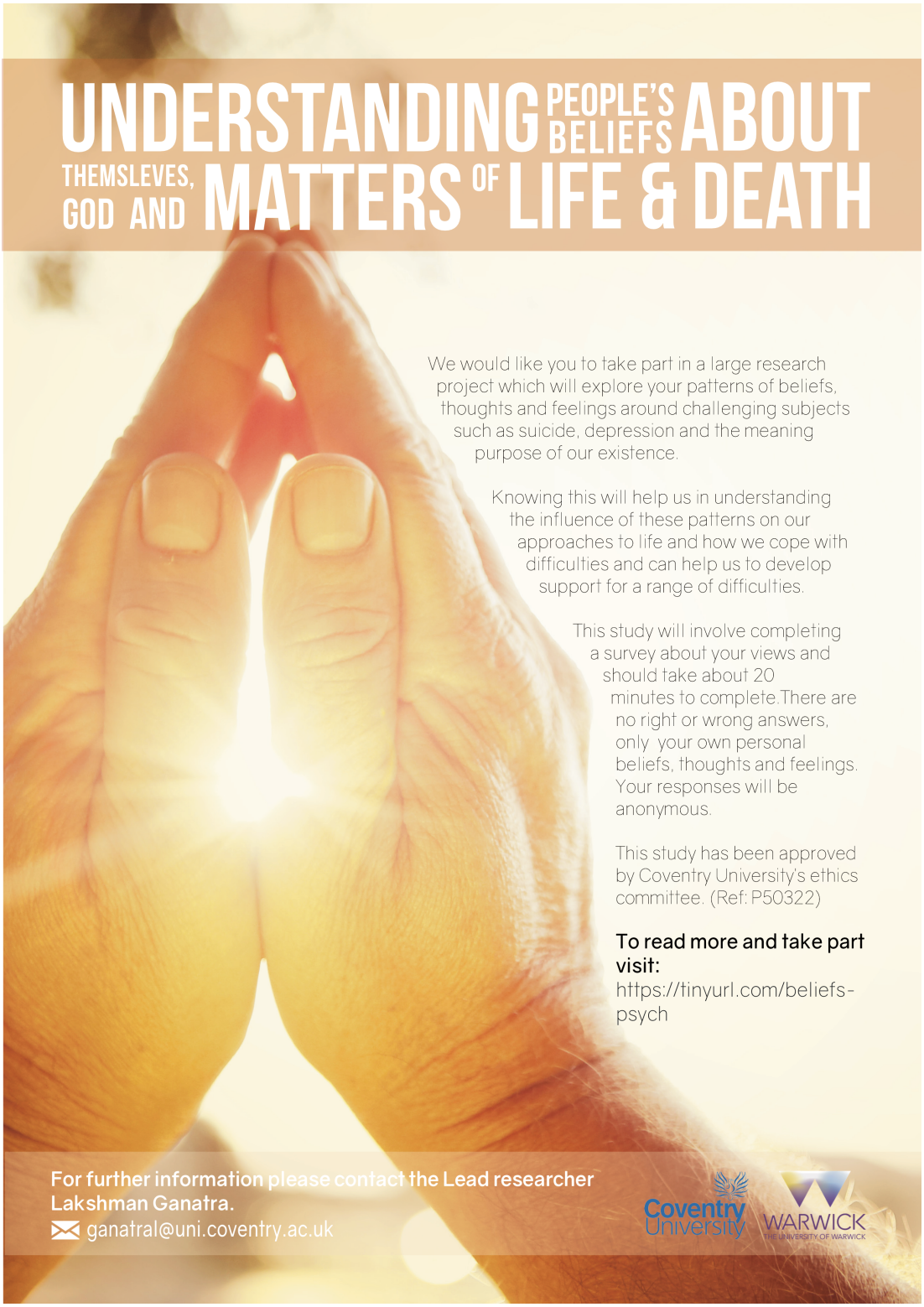
To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author Services http://authorservices.wiley.com/bauthor/faqs_copyright.asp and visit https://authorservices.wiley.com/author-resources/Journal-Authors/licensing-open-access/licensing/open-access-agreements.html.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with Wellcome Trust and Research Councils UK requirements. For more information on this policy and the Journal's compliant self-archiving policy please visit: http://www.wiley.com/go/funderstatement.

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. Please see the full list of terms and conditions.

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

Appendix E: Research Poster



Appendix F: Psychometric Information for Measures

- **Suicide Cognitions Scale (SCS)** (Rudd *et al.,* 2007)
  The SCS is a self-report measure consisting of 18 items that considers the negative cognitions of person having suicidal ideations and targets person's belief system constructing hopelessness characteristic and measures the strength of beliefs consistent with suicidal schemas of unbearability and unlovability. The scale is scored on a 5-point scale, with scores ranging from 18 – 90. The SCS is a free to use highly validated measure. The SCS has been chosen as research indicates depression and hopelessness are key constructs within suicidal cognitions; research shows high validity for SCS with depression, hopelessness and suicidal ideation scales (Ellis & Ruffino, 2015); with a high internal consistency (Cronbach's α = 0.97) and reliability being reported at 0.96 (Rudd *et al.,* 2007). The scale has been validated for use across various populations including, healthy participants (adolescents, adults); in-patients; depressed patients and across cultures (Roaten, 2008).

- **Suicide Behaviours Questionnaire-Revised (SBQ-R)** (Osman *et al.,* 2001)
  The SBQ-R is a 4-item measure used to screen for risk of suicidality. Participants are asked to report their experience of suicidal ideation, planning and attempts. The SBQ-R has shown to be a reliable measure (Cronbach's α = 0.76 – 0.88) demonstrating high internal consistency across clinical ad non-clinical use. The scale has been validated for use in both suicidal and non-suicidal adults and adolescents (Gibbs, 2010; Osman *et al.,* 2001).

- **Brief Resilience Scale (BRS)** (Smith *et al.,* 2008)
  The BRS is a self-report measure to assess resilience as an outcome; the ability to 'bounce back' or recover from stress. It is a 6-item scale on a 5-point Likert scale; with 3 positive and 3 negative items. The BRS is a free to use validated measure with a strong internal consistency (Cronbach's α = 0.80-0.91), re-test reliability of 0.69 and good construct validity (Windle *et al.,* 2011). The scale has been validated for use with healthy participants (adults) and across cultures (Windle *et al.,* 2011).

- **Patient Health Questionnaire-9 (PHQ 9)** (Spitzer, Kronenke, Williams and PHQ Primary Care Study Group, 1999).
  The PHQ-9 is a 9-item self-report measure of depressive symptoms, scored from 0-27. Cut-off scores of 5 indicate mild; 10 – moderate; 15

– moderately severe; 20 – severe. The PHQ-9 is recommended for use of screening for depression. It has been found to be a reliable measure across difference clinical and non-clinical groups (Cronbach's α = 0.86 – 0.89). Test-retest reliability found a strong correlation (0.84) (Kronenke, Spitzer & Williams, 2001). It has been found to be a valid measure and generalisable in various clinical settings (Kroenke *et al.,* 2001).

- **World Health Organisation Quality of Life Assessment-BREF (WHOQOL-BREF)** (WHOQOL Group, 1998)
  The WHOQOL measures satisfaction with life across physical, psychological, social and environmental domains. It uses a 4-point Likert scale with scores ranging from 10-40. The WHOQOL-BREF has been found to be a reliable measure (Cronbach's α = 0.91) (Yao, Chung, Yu & Wang, 2002). It has demonstrated good discriminant construct and cross-cultural validity (Skevington, Lofty & O'Connel, 2004); Yao *et al.,* 2002).

- **Anger/Aggression Questionnaire (AQ)** (Buss & Perry, 1992)
  The AQ is a measure of aggression across 4 domains (Physical Aggression, Verbal Aggression, Anger and Hostility). It uses a 5 point likert scale with scores ranging from 29 – 145. The AQ has a good internal consistency (Cronbach's α = 0.89) and test-retest reliability (Cronbach's α = 0.72 – 0.80) (Buss & Perry, 1992). Strong correlations were found in emotionality, impulsivity, assertiveness and competitiveness (Valdivia-Peralta, Fonesca-Pedrero, Gonzalez-Bravo & Lemos-Giralzdez, 2014).

- **Modified Multi-Dimensional Measure of Religiosity/Spirituality (MMRS)**
  Religiosity/Spirituality was measured using a modified version of the Fetzer Institute (2003) Multi-Dimensional Measure of Religiosity/Spirituality (MMRS). The MMRS is an assessment tool drawing on several different tools which measure religiosity and spirituality. The BMMRS has good reliability across domains (Cronbach's α = 0.64 – 0.91) (Fetzer Institute, 2003)

Appendix G: Survey Questionnaires

Demographic Info

Before you begin we would like to ask you to answer a few general questions about yourself. Please answer each of the questions below by marking – X – in the relevant box or filling in the space provided

01	How old are you?		years
02	Are you:	**Male**	**Female**

03) Please mark an – X – in the relevant box for any of the qualifications you have from the list below:

GCSE's / O'Levels
A levels
Diploma/Certificate
Under-graduate degree or higher
None of the above
Other qualifications *(please specify)*

04) What is your religion?

No Religion	**Buddhist**	**Jewish**
Agnostic	**Christian**	**Muslim**
Atheist	**Hindu**	**Sikh**

5) Do you follow any particular branch / denomination of your faith (e.g. if you are Christian are you Catholic; if you are Muslim are you Sunni etc..)? If so, please say.

06) How would you describe your national identity?

English
Scottish
Welsh
Irish

Northern Irish
British
Other (please specify)

07) What is your main language?

English
Other (please specify)

08) What is your ethnic group?

Choose one section from A to E, then tick one box to best describe your ethnic group or background

A - White	English
	Scottish
	Welsh
	Irish
	Northern Irish
	British Irish Gypsy or Irish Traveller
	Other (please specify)

B – Mixed / Multiple ethnic groups	White and Black Caribbean
	White and Black African
	White and Asian
	Other (please specify)

C – Asian / Asian British	Indian
	Pakistani
	Bangladeshi

	Chinese
	Other (please specify)

D – Black	African
	Caribbean
	British
	Other (please specify)

E- Other ethnic group	

Questions

Quality of Life Questions

Please read each of the statements below and then select the response most appropriate to show how strongly you agree or disagree with each of the statements

1. I am satisfied with my general appearance
   Strongly Disagree – Strongly Agree (1-4)
2. I am satisfied with my personal relationships
   Strongly Disagree – Strongly Agree (1-4)
3. I am satisfied with the support I get from friends
   Strongly Disagree – Strongly Agree (1-4)
4. I am satisfied with my general levels of enthusiasm for everyday life.
   Strongly Disagree – Strongly Agree (1-4)
5. I am satisfied with my ability to focus or concentrate on everyday tasks.
   Strongly Disagree – Strongly Agree (1-4)
6. I am satisfied with the overall quality of my life
   Strongly Disagree – Strongly Agree (1-4)
7. I am satisfied with my general physical health.
   Strongly Disagree – Strongly Agree (1-4)
8. I am satisfied with myself; with who I am.
   Strongly Disagree – Strongly Agree (1-4)
9. I am satisfied with the support I get from my family

Strongly Disagree – Strongly Agree (1-4)

10. I am satisfied with the community where I live.
    Strongly Disagree – Strongly Agree (1-4)

Religiosity

Religious Attachment

1. My faith shapes how I think and act each and every day
   Strongly Agree – Strongly Disagree (1-5)
2. My faith helps me know right from wrong
   Strongly Agree – Strongly Disagree (1-5)
3. I talk with other people about my faith
   Strongly Agree – Strongly Disagree (1-5)
4. I try hard to carry my religious beliefs over into all my other dealings in life.
   Strongly Agree – Strongly Disagree (1-5)
5. Were you raised in a religious tradition for childhood?
   Yes / No
6. How often do you attend religious service?
   Never – Several times a week (1-9)
7. Besides religious services, how often do you take part in other activities at a place of worship such as choir practice or volunteer work?
   Never – Several times a week (1-9)
8. How well do you feel that your general interests, attitudes, beliefs and values fit (as similar to) those of your place of worship?
   Extremely well – Not at all (1-5)
9. I feel at home in this place of worship.
   Strongly Agree – Strongly Disagree (1-5)
10. During religious services, how important to you is praying?
    Extremely important – not at all (1-5)
11. During religious services, how important to you is reading or listening to scriptures?
    Extremely important – not at all (1-5)
12. During religious service, how important to you is listening to the service or drasha?
    Extremely important – not at all (1-5)
13. How often do you pray privately in places other than at church or synagogue?
    Several times a day – Never (1-8)

14. How often do you watch or listen to religious programmes on TV or radio?
    Several times a day – Never (1-8)
15. How often do you read the Bible or other religious literature?
    Several times a day – Never (1-8)

Religious Support

1. How often do the people in your congregation make you feel loved and cared for?
   Very often – Never (1-4)
2. How often do the people in your congregation listen to you talk about your private problems and concerns?
   Very often – Never (1-4)
3. How often do you make the people in your congregation feel loved and cared for?
   Very often – Never (1-4)
4. How often do you listen to the people in your congregation talk about their private problems and concerns?
   Very often – Never (1-4)
5. How often do the people in your congregation make too many demands on you?
   Very often – Never (1-4)
6. How often are the people in your congregation critical of you and the things you do?
   Very often – Never (1-4)
7. If you were ill, how much would the people in your congregation be willing to help out?
   A great deal – None (1-4)
8. If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?
   A great deal – None (1-4)

Aggression

1. Given enough provocation, I may hit another person.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

2. If somebody hits me, I hit back.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

3. There are people who pushed me so far that we end up fighting

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

4. I tell my friends openly when I disagree with them.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

5. When people annoy me, I tell them what I think of them.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

6. I am an even-tempered person.*

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

7. Sometimes I fly off the handle for no good reason.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

8. I have trouble controlling my temper.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

9. At times I feel I have gotten a raw deal out of life.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

10. Other people always seem to get the breaks.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

11. I sometimes feel that people are laughing at me behind my back.

No, Extremely unlike me

No, More unlike me than like me

Yes, More like me than unlike me

Yes, Extremely like me

Anger

1. I feel angry when I think about my life:

   Never – All of the time (1-4)

2. I am so angry that I feel like hurting others, but only in my mind.

   Never – All of the time (1-4)

3. My feelings of anger interfere with my sleep

   Never – All of the time (1-4)

4. My feelings of anger prevent me from thinking in a clear-headed way.

   Never – All of the time (1-4)

Religiosity 2

Religious Coping

1. To help me cope with stressful life events: I think about how my life is part of a larger spiritual force
   A great deal – Not at all (1-4)
2. To help me cope with stressful life events: I work together with God as partners to get through hard times.
   A great deal – Not at all (1-4)
3. To help me cope with stressful life events: I look to God for strength, support and guidance during crises.
   A great deal – Not at all (1-4)
4. I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.
   A great deal – Not at all (1-4)
5. I wonder whether God has abandoned me.
   A great deal – Not at all (1-4)
6. I try to make sense of the situation and decide what to do without relying on God.
   A great deal – Not at all (1-4)
7. To what extent are your spiritual beliefs involved in understanding or dealing with stressful situation in your life?
   Very involved – Not involved at all (1-4)

<u>Religious Forgiveness</u>

1. It is easy for me to admit that I am wrong.
   Always – Never (1-4)
2. If I hear a sermon, I usually think about things I have done wrong.
   Always – Never (1-4)
3. I believe that God has forgiven me for things I have done wrong.
   Always – Never (1-4)
4. I believe that there are times when God has punished me.
   Always – Never (1-4)
5. I believe that when people say they forgive me for something I did, they really mean it.
   Always – Never (1-4)
6. I often feel that no matter what I do now, I will never make up for the mistake I have made in the past.
   Always – Never (1-4)
7. I am able to make up pretty easily with friends who have hurt me in some way.
   Always – Never (1-4)
8. I have grudges which I have held onto for months or years.
   Always – Never (1-4)
9. I have forgiven myself for things that I have done wrong.
   Always – Never (1-4)

10. I often feel like I have failed to live the right kind of life
    Always – Never (1-4)

Religious Values

1. How much is religion a source of strength and comfort to you?
   None / a little / a great deal
2. Do you believe there is a life after death?
   Yes / No / Undecided
3. When faced with a tragic event, I try to remember that God still loves me and that there is hope for the future.
   Strongly agree – Strongly disagree (1-5)
4. My whole approach to life is based on my religion.
   Strongly agree – Strongly disagree (1-5)
5. Although I believe in my religion, many other things are more important in life.
   Strongly agree – Strongly disagree (1-5)
6. My faith helps me know right from wrong.
   Strongly agree – Strongly disagree (1-5)

Attitudes to Suicide

The following questions examine attitudes toward suicide. Read each of the statements and select how strongly you agree or disagree with each of the statements.

1. Suicide is an acceptable means of ending life in some situations.
   Strongly agree – Strongly disagree (1-5)
2. Suicide can never be justified under any circumstances.
   Strongly agree – Strongly disagree (1-5)
3. People who are suicidal can always be helped.
   Strongly agree – Strongly disagree (1-5)
4. Once someone has decided to commit suicide their decision can never be reversed.
   Strongly agree – Strongly disagree (1-5)
5. People attempt suicide because of deep internal conflicts relating to their thoughts and feelings.
   Strongly agree – Strongly disagree (1-5)
6. People attempt suicide because they are seeking revenge for wrongs done to them by others.
   Strongly agree – Strongly disagree (1-5)
7. People attempt suicide because they are being punished by a higher power.
   Strongly agree – Strongly disagree (1-5)

Spirituality

The following questions will explore how spirituality plays a role in your life. Read each statement and select how strongly you agree or disagree with each one.

1. The goals of my life come from how I interpret my spiritual beliefs
   Strongly Disagree – Strongly agree (1-5)
2. Without a sense of spirituality, my daily life would be meaningless.
   Strongly Disagree – Strongly agree (1-5)
3. My spiritual beliefs help me find purpose in even the most painful and confusing events in my life.
   Strongly Disagree – Strongly agree (1-5)
4. What I try to do in my day-to-day life is important to me from a spiritual point of view.
   Strongly Disagree – Strongly agree (1-5)
5. Looking at the most troubling or confusing events from a spiritual perspective adds meaning to my life.
   Strongly Disagree – Strongly agree (1-5)

Resilience

The following statements explore how you cope with difficulties in your life. Please read each of the statements and select how strongly you agree or disagree with each one.

1. I tend to bounce back quickly after hard times
   Strongly Disagree – Strongly agree (1-5)
2. I have a hard time making it through stressful events
   Strongly Disagree – Strongly agree (1-5)
3. It does not take me long to recover from a stressful event
   Strongly Disagree – Strongly agree (1-5)
4. It is hard for me to snap back when something bad happens
   Strongly Disagree – Strongly agree (1-5)
5. I usually come through difficult times with little trouble
   Strongly Disagree – Strongly agree (1-5)
6. I tend to take a long time to get over set-backs in my life
   Strongly Disagree – Strongly agree (1-5)

Suicidal Cognitions

The following questions explore your thoughts around suicide. Please read each of the statements below and then tick a box to show how strongly you agree or disagree with each of the statements

1. The world would be better off without me
   Strongly Disagree – Strongly agree (1-5)
2. Suicide is the only way to solve my problems
   Strongly Disagree – Strongly agree (1-5)
3. I can't stand this pain anymore
   Strongly Disagree – Strongly agree (1-5)
4. I've never been successful at anything
   Strongly Disagree – Strongly agree (1-5)
5. I can't tolerate being this upset any longer
   Strongly Disagree – Strongly agree (1-5)
6. I can never be forgiven for the mistakes I've made
   Strongly Disagree – Strongly agree (1-5)
7. No one can help me solve my problems
   Strongly Disagree – Strongly agree (1-5)
8. It is unbearable when I get this upset
   Strongly Disagree – Strongly agree (1-5)
9. I am completely unworthy of love
   Strongly Disagree – Strongly agree (1-5)
10. Nothing can help solve my problems
    Strongly Disagree – Strongly agree (1-5)
11. It is impossible to describe how badly I feel
    Strongly Disagree – Strongly agree (1-5)
12. I can't cope with my problems any longer
    Strongly Disagree – Strongly agree (1-5)
13. I can't imagine anyone being able to withstand this kind of pain
    Strongly Disagree – Strongly agree (1-5)
14. There is nothing redeeming about me
    Strongly Disagree – Strongly agree (1-5)
15. Suicide is the only way to end this pain
    Strongly Disagree – Strongly agree (1-5)
16. I don't deserve to live another moment
    Strongly Disagree – Strongly agree (1-5)
17. I would rather die now than feel this unbearable pain
    Strongly Disagree – Strongly agree (1-5)
18. No one is as loathsome as me
    Strongly Disagree – Strongly agree (1-5)

Depressive Symptoms

Please read each of the statements below and then tick a box to show how often you have been bothered by any of the following problems **over the last 2 weeks**

1. Little interest or pleasure in doing things

Not at all – Nearly every day (1-4)

2. Feeling down, depressed, or hopeless
   Not at all – Nearly every day (1-4)
3. Trouble falling/staying asleep, sleeping too much
   Not at all – Nearly every day (1-4)
4. Feeling tired or having little energy
   Not at all – Nearly every day (1-4)
5. Poor appetite or overeating
   Not at all – Nearly every day (1-4)
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
   Not at all – Nearly every day (1-4)
7. Trouble concentrating on things, such as reading the newspaper or watching television
   Not at all – Nearly every day (1-4)
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
   Not at all – Nearly every day (1-4)
9. Thoughts that you would be better off dead or of hurting yourself in some way
   Not at all – Nearly every day (1-4)
10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
    Not difficult at all – Extremely Difficult (1-4)

Suicidal Ideation

The following questions explore your relationship to suicide. Please read each of the statements below and then select the phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself?
   Never
   It was just a **brief** passing thought
   I have **had a plan** at least once to kill myself but **did not** try to do it.
   I have **had a plan** at least once to kill myself and really wanted to die
   I have **attempted** to kill myself, but **did not** want to die
   I have **attempted** to kill myself, and really hoped to die
2. How often have you thought about killing yourself in the past year?

   Never

   Rarely (1 time)

   Sometimes (2 times)

Often (3-4 times)

Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it?

   No

   Yes, at one time, but **did not** really want to die

   Yes, at one time, and really wanted to do it

   Yes, more than once, but **did not** want to do it

   Yes, more than once, and really wanted to do it

4. How likely is that you will attempt suicide someday?

   Never

   No chance at all

   Rather unlikely

   Unlikely

   Likely

   Rather Likely

   Very Likely

Appendix H: Ethical Approval (Empirical Paper)

Certificate of Ethical Approval

Applicant:

Lakshman Ganatra

Project Title:

Examining the protective influence of religiosity and spirituality against the risk of suicidality amongst different faith communities.

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

22 February 2017

Project Reference Number:

P50322

Appendix I: Participant Information Sheet

Understanding people's beliefs about themselves and matters of life and death.

Lead Researcher: Lakshman Ganatra (Trainee Clinical Psychologist at the Universities of Coventry & Warwick

Contact: ganatral@uni.coventry.ac.uk - 024 7688 8328

Supervised by: Dr Anthony Colombo

We would like to invite you to take part in a research study. Before you decide whether you want to take part in the study, it is important to understand why we are doing the research and what it will involve. Please do not hesitate to contact me if you have any questions or concerns before deciding whether you want to take part or not.

What is the purpose of this study?

The main aim of this study is to gain a clearer understanding of the many different ways we think and feel about challenging matters of life and death such as suicide, depression, and the meaning/purpose of our existence. Collecting such information is important because it is believed that each of us possess a particular pattern of thoughts and feelings which influence how we approach life and how well we manage to cope with things that can happen to us. If we can learn about these patterns, then we may be able to develop methods of support that will help people with different sorts of mood difficulties such as depression, suicidal thoughts, grief and distress. There are no right or wrong answers, only your own personal beliefs, thoughts and feelings are important.

Why have I been invited to take part?

This is a large research study and you have been asked to take part because we are interested in finding out more about patterns of beliefs, thoughts and feelings across a broad range of men

Do I have to take part?

No. Taking part in this study is completely optional. If you decide to take part, then you are free to stop the study at any time and are not obliged to submit the survey. You can save your answers and come back to them before completing the survey if you wish. We cannot access your information until you formally submit your questionnaire.

As the survey is anonymous, once you have submitted your answers it will not be possible to withdraw your data. You will be asked to actively confirm that you are happy to submit your answers on the last page.

What is involved in taking part?

The study involves completing several short questionnaires. To make completing these questionnaires as easy as possible, you will only be asked to select a response from a list of options. The questionnaires will ask about a range of things, including: your beliefs and thoughts; how you manage your feelings; and how you approach problems. We also need to ask about your mental health well-being, which will include questions on sensitive issues such as depression, suicidal thoughts, and quality of life. Due to the sensitive nature of these questions, we ask you to ensure that you are in a private place whilst you complete this survey; somewhere you feel comfortable and safe place.

It is expected that completing these questionnaires will take 15-20 minutes of your time. You can complete these at your own time and pace, and save and come back to it if needs be. If you choose to take part, you will be asked to complete a consent form to indicate you have read and understood this participant information sheet.

Will the information be kept confidential?

Your responses will be anonymous. We will change your questionnaire responses to numerical scores and these will be stored as electronic information on a secure university hard drive which will be encrypted and password protected. The data will only be accessible by the research team. Everyone's responses will be summed together, so it will not be possible to identify individuals in this study.

You will not be required to give any identifiable information. However, you will be offered the chance to give your email address to receive an information sheet once the results have been analysed if you wish. In this case, your email address will be kept confidential, with only the research team having access to it and using it solely to inform you of the results. Once we have sent you a summary of the findings, your e-mail will be deleted from our database.

What are the benefits of taking part?

You may find the questionnaire interesting to complete and you will have the opportunity to receive feedback about the overall results of the study when it is finished. It is hoped the findings will contribute in understanding how to develop methods of support that will help people with different sorts of mood difficulties such as depression, suicidal thoughts, grief and distress.

What are the potential disadvantages of taking part?

We will be asking you about your personal beliefs, thoughts and feelings, across a range of subjects and sometimes this can be quite upsetting. It is not anticipated that this will cause any distress. However, if answering these questions does leave you feeling upset or distressed we would suggest you contact your GP in the first instance for support.

Further support can also be found below:

- **SupportLine Telephone Helpline: 01708 765200**, email info@supportline.org.uk - Provides emotional support and details of support groups, helplines, agencies and counsellors throughout the UK.
- **Calm: 0800 585858, www.thecalmzone.net** - Campaign Against Living Miserably Help and support for young men aged 15-35 on issues which include depression and suicide.
- **HopeLine UK – 0800 068 4141** – www.papyrus-uk.org

  for practical advice on suicide prevention.
- **Samaritans: Helpline: 116 123 (free of charge from a landline or mobile)**
  Email: jo@samaritans.org - www.samaritans.org
  24 hour helpline offering emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide
- **Premier Lifeline - 0300 111 0101** www.premier.org.uk/lifeline
  Helpline providing a listening service, information, emotional and spiritual support from a Christian perspective.
- **Black and Asian Therapists Network**

  Email: Eugene@baatn.org.uk - http://www.baatn.org.uk

  UK's largest independent organisation to specialise in working with Black and Asian clients. Also has online directory of Black and Asian therapists across the UK.
- **Muslim Community Helpline**

  http://www.muslimcommunityhelpline.org.uk

  Tel: 020 8904 8193 or 020 8908 6715 Mon-Fri 10am-1pm

  Email: ess4m@btinternet.com

  Confidential, non-judgemental listening and emotional support service for women, men, youth and children.

If you would like more information about mental health, we would recommend the following:

- https://www.menshealthforum.org.uk
- https://www.mind.org.uk
- http://www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx
- https://www.rethink.org/

These numbers along with details of other support organisations will be listed again at the end of this survey.

What will happen with the results of the study?

It is anticipated that the results will be used to help services better understand the how people's personal beliefs and approaches to topics of life and death can impact on coping. The findings will be communicated to a range of audiences through publications and reports.

If you have any questions or concerns following the survey regarding your health needs, please contact your GP in the first instance. You will not be provided with individual feedback on the questionnaires, however if you would like to know the overall outcome of the study you can leave your email address at the end and you will be sent a summary of the key findings.

Who has reviewed this study?

Coventry University's ethics committee have reviewed and approved this study.

Questions or Concerns

If you have any questions, queries or concerns regarding this research please contact the lead researcher, Lakshman Ganatra by emailing at ganatral@uni.coventry.ac.uk

Appendix J: Consent Form

Consent Form

Please read the following questions, if you agree to take part, please select "Yes" to each statement. All questions must be answered "Yes" in order to take part.

1. I have read and understood the information about this study that has been provided.
2. I have had the opportunity to consider the information and realise that if I have any questions regarding the research, I can email the lead researcher - Lakshman Ganatra at ganatral@uni.coventry.ac.uk.
3. I have seen the further support information and am aware where I can access support if I need to.
4. I understand that my participation is completely voluntary. I am aware that I have the right to stop the questionnaire at any point and not submit my answers.
5. I understand that the study is anonymous and that once I have submitted the answers I will not be able to withdraw my data.
6. I understand that my responses will be kept anonymous and that I cannot be identified from the information I have provided. However, if I give my email address to find out more information regarding the study's overall results, that this will be kept confidential.
7. I understand that the data collected will be retrained for 5 years before being destroyed in keeping with the Coventry University's Data Protection policy
8. I understand that any point I may contact the lead researcher Lakshman Ganatra at ganatral@uni.coventry.ac.uk
9. I confirm that I am 18 years of age or older and can take part in the study.
10. I agree to take part in this study.

Appendix K: Debrief Sheet

Debrief

Thank you for taking part in this important study

Thank you for participating in this study. As previously mentioned, all answers are anonymous.

This study looked at a range of psychological and social factors (religious and spiritual beliefs, resilience to distressing events and factors associated with people's quality of life) that might help protect people from different sorts of mood difficulties such as depression, suicidal thoughts, grief and distress. It is important for professionals and policy makers to be aware of these issues in order to decide how best to support people and what role religious and spiritual matters play in these difficulties.

If this study has caused you any distress, or you feel the need for some support, we would recommend you contact your GP in the first instance who can refer you onto the most appropriate service for you in your area.

If you belong to a particular faith group / congregation, you may wish to contact and speak with someone you feel comfortable with. Other organisations that can provide support are:

- **SupportLine Telephone Helpline: 01708 765 200**
  email: info@supportline.org.uk - provides emotional support and details of support groups, helplines, agencies and counsellors throughout the UK.
- **CALM: 0800 585 858** www.calmzone.net
  Campaign Against Living Miserably help and support for young men aged 15 - 35 on issues which include depression and suicide.
- **HopeLine: 0800 068 4141** www.papyrus-uk.org
  For practical advice on suicide prevention.
- **Samaritans: 116 123** (free from landline and mobile) www.samaritans.org
  24 hour helpline offering emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.
- **Premier Lifeline: 0300 111 0101** www.premier.org.uk/lifeline
  Helpline providing a listening service, information, emotional and spiritual support from a Christian perspective.
- **Sikh Helpline: 0845 644 0704** www.sikhhelpline.com
  A professional and confidential telephone counselling and email inquiry service where you can get help, advice, counselling and information on Sikhism and cultural issues.
- **Black and Asian Therapists Network** www.baatn.org.uk

UK's largest independent organisation to specialise in working with Black and Asian clients. It provides a directory of Black and Asian therapists across the UK.

- **Muslim Community Helpline: 020 8904 8193 or 020 8908 6715** www.muslimcommunityhelpline.org.uk

  Confidential, non-judgemental listening and emotional support service for women, men, youth and children.

- **Jewish Helpline: 0800 652 9249** www.jewishhelpline.co.uk

  A non-judgemental, listening ear providing support for people across the Jewish community who are in crises, lonely, anxious, depressed or suicidal.

- **Saneline: 0845 767 8000** www.saneline.org.uk

  A national out-of-hours telephone helpline offering emotional support and information for people affected by mental health problems.

  If you would like more information about mental health, we would recommend the following:

  - https://www.menshealthforum.org.uk
  - https://www.mind.org.uk
  - http://www.nhs.uk/livewell/mentalhealth/Pages/Mentalhealthhome.aspx
  - https://www.rethink.org/

If you have any questions specifically regarding this research study, please contact the lead researcher Lakshman Ganatra by emailing ganatral@uni.coventry.ac.uk.

Thank you for your participation

Appendix L: SPSS Output

Demographics

Religion

Statistics

What is your religion?

N	Valid	229
	Missing	2

What is your religion?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Religion	55	23.8	24.0	24.0
	Agnostic	4	1.7	1.7	25.8
	Atheist	25	10.8	10.9	36.7
	Buddhist	3	1.3	1.3	38.0
	Christian	63	27.3	27.5	65.5
	Hindu	51	22.1	22.3	87.8
	Jewish	2	.9	.9	88.6
	Muslim	9	3.9	3.9	92.6
	Sikh	8	3.5	3.5	96.1
	Other	9	3.9	3.9	100.0
	Total	229	99.1	100.0	
Missing	System	2	.9		
Total		231	100.0		

Statistics

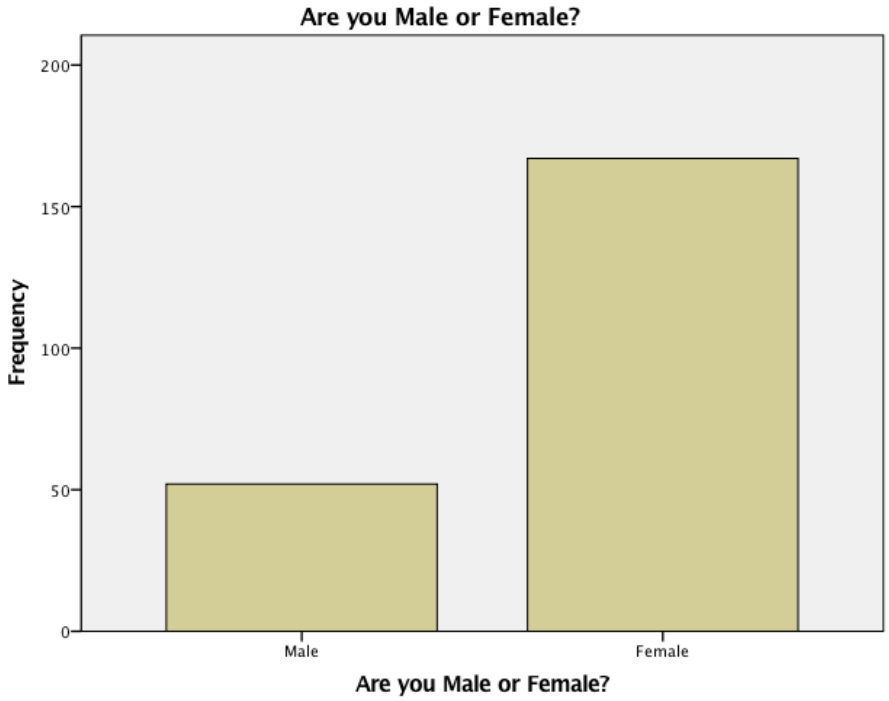
What is your religion?

N	Valid	225
	Missing	0

What is your religion?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Religion	55	24.4	24.4	24.4
	Atheist	25	11.1	11.1	35.6
	Christian	63	28.0	28.0	63.6
	Hindu	51	22.7	22.7	86.2
	Other	31	13.8	13.8	100.0
	Total	225	100.0	100.0	

Gender



Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Are you Male or Female? * What is your religion?	219	97.3%	6	2.7%	225	100.0%

Are you Male or Female? * What is your religion? Crosstabulation

			What is your religion?					
			No Religion	Atheist	Christian	Hindu	Other	Total
Are you Male or Female?	Male	Count	11	10	8	14	9	52
		Expected Count	12.6	5.9	14.2	12.1	7.1	52.0
	Female	Count	42	15	52	37	21	167
		Expected Count	40.4	19.1	45.8	38.9	22.9	167.0
Total		Count	53	25	60	51	30	219
		Expected Count	53.0	25.0	60.0	51.0	30.0	219.0

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	8.537[a]	4	.074
Likelihood Ratio	8.573	4	.073
Linear-by-Linear Association	.286	1	.593
N of Valid Cases	219		

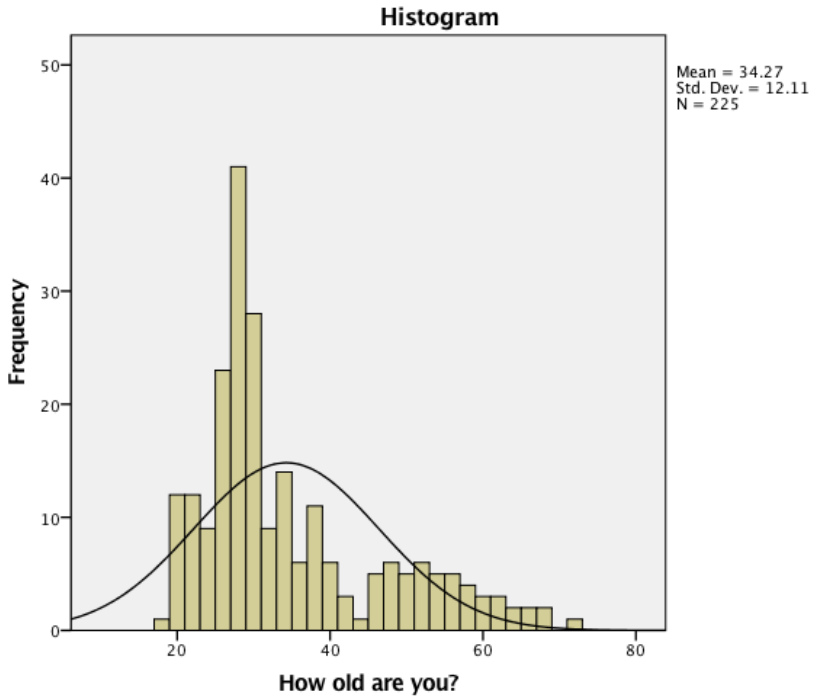
a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.94.

Age

Statistics

How old are you?

N	Valid	225
	Missing	0
Mean		34.27
Median		29.00
Std. Deviation		12.110
Skewness		1.085
Std. Error of Skewness		.162
Kurtosis		.258
Std. Error of Kurtosis		.323
Minimum		18
Maximum		71



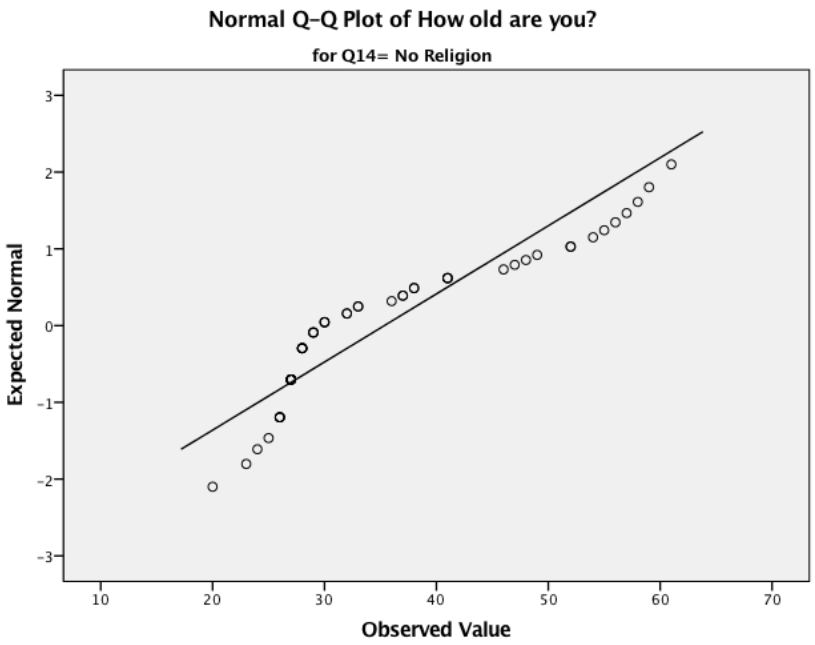
Case Processing Summary

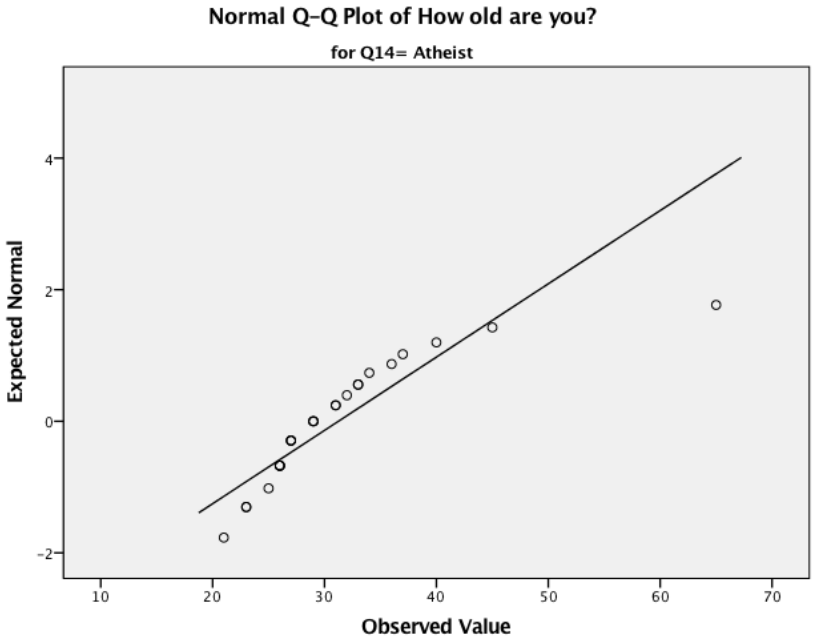
		Cases					
		Valid		Missing		Total	
	What is your religion?	N	Percent	N	Percent	N	Percent
How old are you?	No Religion	55	100.0%	0	0.0%	55	100.0%
	Atheist	25	100.0%	0	0.0%	25	100.0%
	Christian	63	100.0%	0	0.0%	63	100.0%
	Hindu	51	100.0%	0	0.0%	51	100.0%
	Other	31	100.0%	0	0.0%	31	100.0%

Tests of Normality

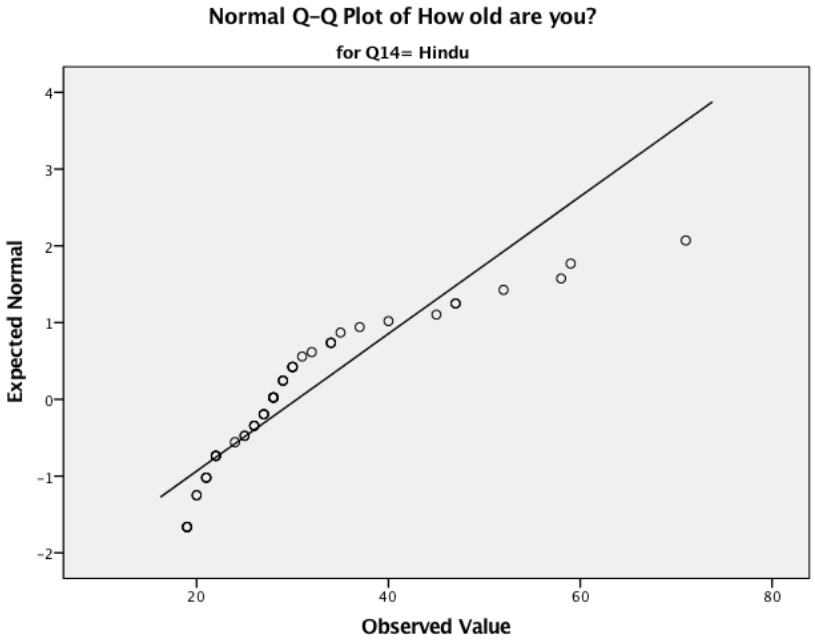
		Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	What is your religion?	Statistic	df	Sig.	Statistic	df	Sig.
How old are you?	No Religion	.228	55	.000	.843	55	.000
	Atheist	.182	25	.032	.774	25	.000
	Christian	.161	63	.000	.908	63	.000
	Hindu	.222	51	.000	.813	51	.000
	Other	.217	31	.001	.872	31	.002

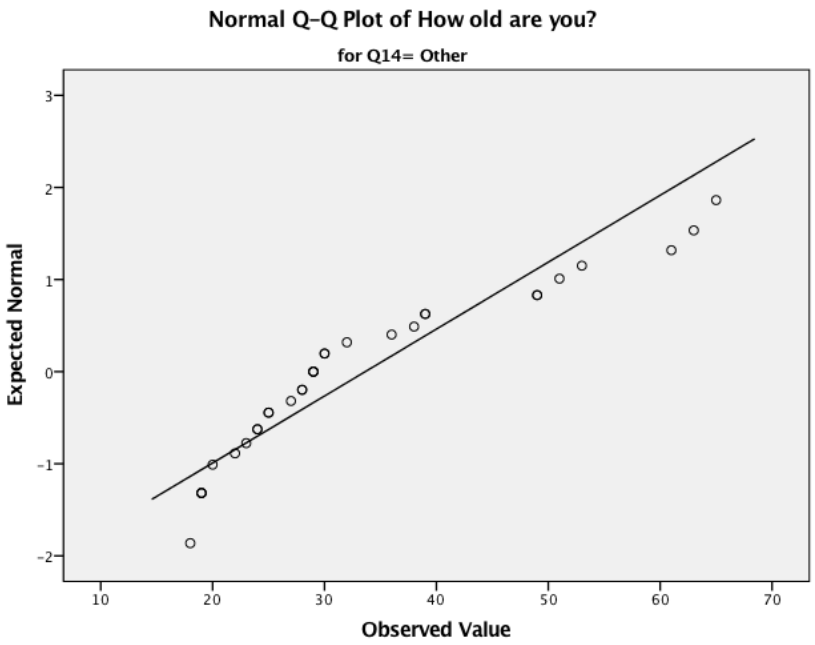
a. Lilliefors Significance Correction

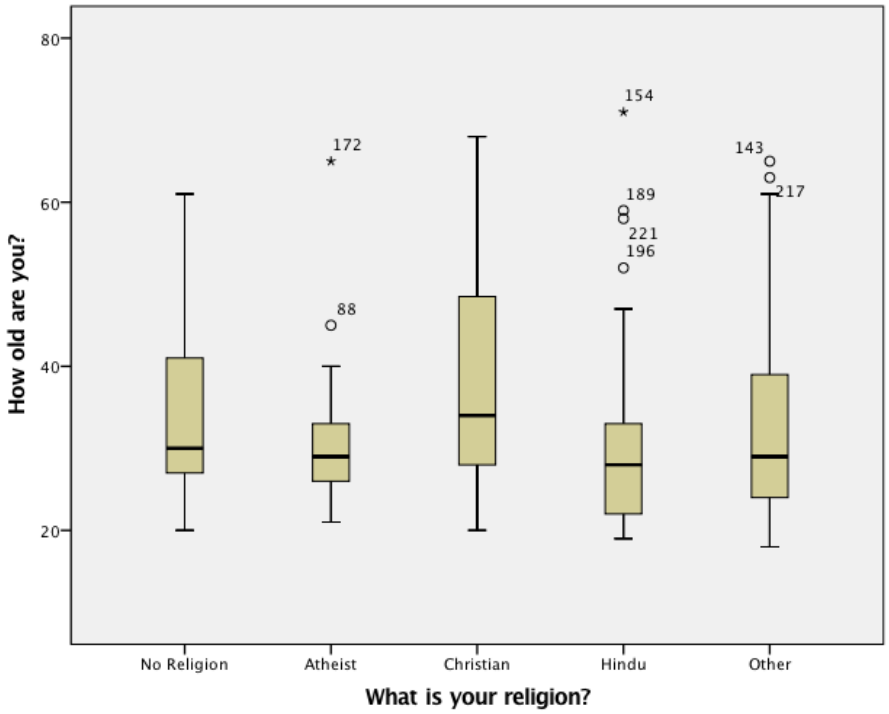

Normal Q-Q Plot of How old are you?
for Q14= No Religion
Expected Normal
Observed Value
3
2
1
0
-1
-2
-3
10
20
30
40
50
60
70


Normal Q-Q Plot of How old are you?
for Q14= Atheist
Expected Normal
Observed Value
4
2
0
-2
10
20
30
40
50
60
70


Normal Q-Q Plot of How old are you?
for Q14= Christian
Expected Normal
Observed Value
3
2
1
0
-1
-2
-3
20
40
60
80


Normal Q-Q Plot of How old are you?
for Q14= Hindu
Expected Normal
Observed Value
4
3
2
1
0
-1
-2
20
40
60
80


Normal Q-Q Plot of How old are you?
for Q14= Other
Expected Normal
Observed Value
3
2
1
0
-1
-2
10
20
30
40
50
60
70


How old are you?
What is your religion?
No Religion
Atheist
Christian
Hindu
Other
80
60
40
20
154
172
143
189
217
221
196
88

1) Is there a difference between Faith and non-Faith communities in their propensity towards suicidality?

Suicide

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalSuicide	1	77	26.8182	10.71119	1.22065
	2	110	30.9455	13.83311	1.31893

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalSuicide	Equal variances assumed	9.096	.003	-1.511	162	.133	-4.31429	2.85499	-9.95207	1.32350
	Equal variances not assumed			-2.289	55.366	.026	-4.31429	1.88460	-8.09055	-.53802

Depression

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalDepres	1	79	15.2405	5.74950	.64687
	2	142	17.3944	7.21892	.60580

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalDepres	Equal variances assumed	5.444	.021	-2.279	219	.024	-2.15386	.94495	-4.01623	-.29149
	Equal variances not assumed			-2.430	192.784	.016	-2.15386	.88625	-3.90184	-.40588

Satisfaction with Life

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalSatLife	1	79	37.5316	6.06342	.68219
	2	143	37.8392	6.75596	.56496

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalSatLife	Equal variances assumed	1.388	.240	-.337	220	.737	-.30752	.91383	-2.10850	1.49347
	Equal variances not assumed			-.347	176.165	.729	-.30752	.88575	-2.05557	1.44054

Resilience

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalResil	1	80	20.1750	4.97532	.55626
	2	143	19.5944	5.10763	.42712

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalResil	Equal variances assumed	.037	.849	.822	221	.412	.58059	.70657	-.81187	1.97306
	Equal variances not assumed			.828	167.269	.409	.58059	.70132	-.80399	1.96518

Anger, Aggression, Clinical Anger, Hostility

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalAgress	1	79	10.2785	2.74066	.30835
	2	142	10.5211	2.57571	.21615
TotalAnger	1	80	5.4250	1.78443	.19950
	2	145	5.8759	1.82910	.15190
TotalClinAng	1	79	5.3671	1.44273	.16232
	2	145	5.5241	1.90059	.15784
TotalHistility	1	80	5.6750	1.97308	.22060
	2	142	5.7324	2.03834	.17105

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalAgress	Equal variances assumed	.703	.403	-.656	219	.513	-.24265	.36993	-.97173	.48644
	Equal variances not assumed			-.644	153.047	.520	-.24265	.37656	-.98658	.50128
TotalAnger	Equal variances assumed	.090	.765	-1.785	223	.076	-.45086	.25255	-.94856	.04684
	Equal variances not assumed			-1.798	166.452	.074	-.45086	.25075	-.94592	.04420
TotalClinAng	Equal variances assumed	4.408	.037	-.641	222	.522	-.15705	.24519	-.64025	.32615
	Equal variances not assumed			-.694	198.910	.489	-.15705	.22641	-.60351	.28942
TotalHistility	Equal variances assumed	.820	.366	-.204	220	.839	-.05739	.28170	-.61258	.49779
	Equal variances not assumed			-.206	168.442	.837	-.05739	.27915	-.60847	.49368

Multiple Comparisons

Dunnett T3

Dependent Variable	(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
TotalAgress	No Religion	Atheist	.1667	.69169	1.000	-1.8686	2.2019
		Christian	.3968	.51225	.997	-1.0644	1.8580
		Hindu	-.2411	.50901	1.000	-1.6969	1.2147
		Other	-1.1149	.53000	.319	-2.6425	.4126
	Atheist	No Religion	-.1667	.69169	1.000	-2.2019	1.8686
		Christian	.2302	.68023	1.000	-1.7759	2.2362
		Hindu	-.4078	.67779	.999	-2.4096	1.5940
		Other	-1.2816	.69369	.503	-3.3282	.7650
	Christian	No Religion	-.3968	.51225	.997	-1.8580	1.0644
		Atheist	-.2302	.68023	1.000	-2.2362	1.7759
		Hindu	-.6380	.49331	.884	-2.0469	.7709

		Other	-1.5118*	.51495	.043	-2.9959	-.0277
	Hindu	No Religion	.2411	.50901	1.000	-1.2147	1.6969
		Atheist	.4078	.67779	.999	-1.5940	2.4096
		Christian	.6380	.49331	.884	-.7709	2.0469
		Other	-.8738	.51172	.605	-2.3528	.6052
	Other	No Religion	1.1149	.53000	.319	-.4126	2.6425
		Atheist	1.2816	.69369	.503	-.7650	3.3282
		Christian	1.5118*	.51495	.043	.0277	2.9959
		Hindu	.8738	.51172	.605	-.6052	2.3528
TotalHistility	No Religion	Atheist	.7778	.47703	.664	-.6215	2.1770
		Christian	.3095	.37031	.994	-.7468	1.3659
		Hindu	.1785	.39899	1.000	-.9632	1.3202
		Other	.3582	.47120	.997	-1.0126	1.7291
	Atheist	No Religion	-.7778	.47703	.664	-2.1770	.6215
		Christian	-.4683	.46770	.974	-1.8434	.9069
		Hindu	-.5993	.49073	.912	-2.0348	.8362
		Other	-.4195	.55104	.997	-2.0286	1.1895
	Christian	No Religion	-.3095	.37031	.994	-1.3659	.7468
		Atheist	.4683	.46770	.974	-.9069	1.8434
		Hindu	-.1310	.38780	1.000	-1.2401	.9780
		Other	.0487	.46175	1.000	-1.2969	1.3943

	Hindu	No Religion	-.1785	.3989	1.000	-1.3202	.9632
		Atheist	.5993	.4907	.912	-.8362	2.0348
		Christian	.1310	.3878	1.000	-.9780	1.2401
		Other	.1798	.4850	1.000	-1.2288	1.5883
	Other	No Religion	-.3582	.4712	.997	-1.7291	1.0126
		Atheist	.4195	.5510	.997	-1.1895	2.0286
		Christian	-.0487	.4617	1.000	-1.3943	1.2969
		Hindu	-.1798	.4850	1.000	-1.5883	1.2288
TotalAnger	No Religion	Atheist	.4861	.4271	.942	-.7647	1.7370
		Christian	-.0714	.3479	1.000	-1.0639	.9210
		Hindu	-.5378	.3659	.780	-1.5850	.5093
		Other	-.1130	.4000	1.000	-1.2723	1.0463
	Atheist	No Religion	-.4861	.4271	.942	-1.7370	.7647
		Christian	-.5575	.4242	.869	-1.8002	.6851
		Hindu	-1.0239	.4391	.207	-2.3067	.2589
		Other	-.5991	.4679	.886	-1.9671	.7688
	Christian	No Religion	.0714	.3479	1.000	-.9210	1.0639
		Atheist	.5575	.4242	.869	-.6851	1.8002
		Hindu	-.4664	.3625	.887	-1.5027	.5699
		Other	-.0416	.3969	1.000	-1.1916	1.1084
	Hindu	No Religion	.5378	.3659	.780	-.5093	1.5850

		Atheist	1.0239	.43913	.207	-.2589	2.3067
		Christian	.4664	.36255	.887	-.5699	1.5027
		Other	.4248	.41280	.970	-.7701	1.6197
	Other	No Religion	.1130	.40007	1.000	-1.0463	1.2723
		Atheist	.5991	.46794	.886	-.7688	1.9671
		Christian	.0416	.39696	1.000	-1.1084	1.1916
		Hindu	-.4248	.41280	.970	-1.6197	.7701
TotalClinAng	No Religion	Atheist	.4954	.33407	.770	-.4803	1.4710
		Christian	.2989	.28158	.965	-.5042	1.1021
		Hindu	-.3353	.41029	.994	-1.5174	.8468
		Other	-.1181	.35765	1.000	-1.1593	.9230
	Atheist	No Religion	-.4954	.33407	.770	-1.4710	.4803
		Christian	-.1964	.32990	1.000	-1.1606	.7677
		Hindu	-.8307	.44484	.482	-2.1149	.4536
		Other	-.6135	.39682	.726	-1.7716	.5446
	Christian	No Religion	-.2989	.28158	.965	-1.1021	.5042
		Atheist	.1964	.32990	1.000	-.7677	1.1606
		Hindu	-.6342	.40689	.717	-1.8069	.5384
		Other	-.4171	.35375	.929	-1.4475	.6134
	Hindu	No Religion	.3353	.41029	.994	-.8468	1.5174
		Atheist	.8307	.44484	.482	-.4536	2.1149

		Christian	.6342	.40689	.717	-.5384	1.8069
		Other	.2172	.46281	1.000	-1.1162	1.5506
	Other	No Religion	.1181	.35765	1.000	-.9230	1.1593
		Atheist	.6135	.39682	.726	-.5446	1.7716
		Christian	.4171	.35375	.929	-.6134	1.4475
		Hindu	-.2172	.46281	1.000	-1.5506	1.1162

Based on observed means.
The error term is Mean Square(Error) = 3.074.
*. The mean difference is significant at the .05 level.

2) Can any differences between Faith and non-Faith community's propensity towards suicidality be explained through religious affiliation?

MANOVA

Box's Test of Equality of Covariance Matrices[a]

Box's M	81.152
F	1.929
df1	40
df2	42875.342
Sig.	.000

Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.

a. Design: Intercept + Q14

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.990	5166.888[b]	4.000	202.000	.000	.990
	Wilks' Lambda	.010	5166.888[b]	4.000	202.000	.000	.990
	Hotelling's Trace	102.315	5166.888[b]	4.000	202.000	.000	.990
	Roy's Largest Root	102.315	5166.888[b]	4.000	202.000	.000	.990
Q14	Pillai's Trace	.106	1.393	16.000	820.000	.138	.026
	Wilks' Lambda	.897	1.396	16.000	617.758	.137	.027
	Hotelling's Trace	.111	1.395	16.000	802.000	.137	.027
	Roy's Largest Root	.061	3.148[c]	4.000	205.000	.015	.058

a. Design: Intercept + Q14

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Levene's Test of Equality of Error Variances[a]

	F	df1	df2	Sig.
TotalSuicide	2.327	4	205	.058
TotalDepres	2.147	4	205	.076
TotalSatLife	.808	4	205	.522
TotalResil	1.439	4	205	.222

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Q14

What is your religion?

Dependent Variable	What is your religion?	Mean	Std. Error	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
TotalSuicide	No Religion	27.923	1.751	24.472	31.375
	Atheist	24.500	2.577	19.419	29.581
	Christian	26.759	1.658	23.490	30.027
	Hindu	31.688	1.822	28.095	35.280
	Other	28.429	2.386	23.725	33.132
TotalDepres	No Religion	15.923	.945	14.060	17.786
	Atheist	14.125	1.391	11.383	16.867
	Christian	17.172	.895	15.408	18.936
	Hindu	17.896	.983	15.957	19.835
	Other	16.893	1.288	14.354	19.432
TotalSatLife	No Religion	37.365	.920	35.552	39.179
	Atheist	37.667	1.354	34.997	40.336
	Christian	38.190	.871	36.472	39.907
	Hindu	37.771	.957	35.883	39.659
	Other	37.357	1.254	34.885	39.829
TotalResil	No Religion	19.635	.710	18.235	21.035
	Atheist	21.042	1.045	18.981	23.102
	Christian	19.103	.672	17.778	20.429
	Hindu	19.979	.739	18.522	21.436
	Other	20.071	.968	18.163	21.979

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	TotalSuicide	1037.513[a]	4	259.378	1.628	.169	.031
	TotalDepres	272.463[b]	4	68.116	1.467	.213	.028
	TotalSatLife	23.211[c]	4	5.803	.132	.971	.003
	TotalResil	70.125[d]	4	17.531	.669	.614	.013
Intercept	TotalSuicide	144066.985	1	144066.985	904.016	.000	.815
	TotalDepres	49934.545	1	49934.545	1075.525	.000	.840
	TotalSatLife	263394.032	1	263394.032	5985.423	.000	.967
	TotalResil	73994.786	1	73994.786	2822.005	.000	.932
Q14	TotalSuicide	1037.513	4	259.378	1.628	.169	.031
	TotalDepres	272.463	4	68.116	1.467	.213	.028
	TotalSatLife	23.211	4	5.803	.132	.971	.003
	TotalResil	70.125	4	17.531	.669	.614	.013
Error	TotalSuicide	32669.483	205	159.363			
	TotalDepres	9517.751	205	46.428			
	TotalSatLife	9021.213	205	44.006			
	TotalResil	5375.232	205	26.221			
Total	TotalSuicide	199975.000	210				
	TotalDepres	67957.000	210				
	TotalSatLife	307817.000	210				
	TotalResil	87655.000	210				
Corrected Total	TotalSuicide	33706.995	209				
	TotalDepres	9790.214	209				
	TotalSatLife	9044.424	209				
	TotalResil	5445.357	209				

a. R Squared = .031 (Adjusted R Squared = .012)
b. R Squared = .028 (Adjusted R Squared = .009)
c. R Squared = .003 (Adjusted R Squared = -.017)
d. R Squared = .013 (Adjusted R Squared = -.006)

Multiple Comparisons

Dunnett T3

Dependent Variable	(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
TotalSuicide	No Religion	Atheist	3.4231	2.23062	.735	-3.0190	9.8651
		Christian	1.1645	2.37548	1.000	-5.6176	7.9465
		Hindu	-3.7644	2.66300	.816	-11.3940	3.8652
		Other	-.5055	3.01509	1.000	-9.3084	8.2974
	Atheist	No Religion	-3.4231	2.23062	.735	-9.8651	3.0190
		Christian	-2.2586	2.26198	.976	-8.7793	4.2620
		Hindu	-7.1875	2.56226	.062	-14.5812	.2062
		Other	-3.9286	2.92650	.854	-12.5352	4.6781
	Christian	No Religion	-1.1645	2.37548	1.000	-7.9465	5.6176
		Atheist	2.2586	2.26198	.976	-4.2620	8.7793

		Hindu	-4.9289	2.68932	.506	-12.6265	2.7687
		Other	-1.6700	3.03836	1.000	-10.5291	7.1892
	Hindu	No Religion	3.7644	2.66300	.816	-3.8652	11.3940
		Atheist	7.1875	2.56226	.062	-.2062	14.5812
		Christian	4.9289	2.68932	.506	-2.7687	12.6265
		Other	3.2589	3.26808	.976	-6.2170	12.7349
	Other	No Religion	.5055	3.01509	1.000	-8.2974	9.3084
		Atheist	3.9286	2.92650	.854	-4.6781	12.5352
		Christian	1.6700	3.03836	1.000	-7.1892	10.5291
		Hindu	-3.2589	3.26808	.976	-12.7349	6.2170
TotalDepres	No Religion	Atheist	1.7981	1.18278	.745	-1.6143	5.2104
		Christian	-1.2493	1.34099	.986	-5.0779	2.5792
		Hindu	-1.9728	1.37708	.805	-5.9149	1.9694
		Other	-.9698	1.61556	1.000	-5.6823	3.7428
	Atheist	No Religion	-1.7981	1.18278	.745	-5.2104	1.6143

		Christian	-3.0474	1.24938	.154	-6.6423	.5475
		Hindu	-3.7708*	1.28805	.045	-7.4878	-.0539
		Other	-2.7679	1.54037	.539	-7.3028	1.7671
	Christian	No Religion	1.2493	1.34099	.986	-2.5792	5.0779
		Atheist	3.0474	1.24938	.154	-.5475	6.6423
		Hindu	-.7234	1.43469	1.000	-4.8243	3.3774
		Other	.2796	1.66494	1.000	-4.5594	5.1185
	Hindu	No Religion	1.9728	1.37708	.805	-1.9694	5.9149
		Atheist	3.7708*	1.28805	.045	.0539	7.4878
		Christian	.7234	1.43469	1.000	-3.3774	4.8243
		Other	1.0030	1.69415	1.000	-3.9184	5.9244
	Other	No Religion	.9698	1.61556	1.000	-3.7428	5.6823
		Atheist	2.7679	1.54037	.539	-1.7671	7.3028
		Christian	-.2796	1.66494	1.000	-5.1185	4.5594
		Hindu	-1.0030	1.69415	1.000	-5.9244	3.9184

TotalSatLife	No Religion	Atheist	-.3013	1.36882	1.000	-4.2756	3.6730
		Christian	-.8243	1.28129	.999	-4.4827	2.8342
		Hindu	-.4054	1.36289	1.000	-4.3058	3.4949
		Other	.0082	1.58800	1.000	-4.6169	4.6333
	Atheist	No Religion	.3013	1.36882	1.000	-3.6730	4.2756
		Christian	-.5230	1.35576	1.000	-4.4588	3.4129
		Hindu	-.1042	1.43313	1.000	-4.2571	4.0487
		Other	.3095	1.64868	1.000	-4.5111	5.1302
	Christian	No Religion	.8243	1.28129	.999	-2.8342	4.4827
		Atheist	.5230	1.35576	1.000	-3.4129	4.4588
		Hindu	.4188	1.34977	1.000	-3.4413	4.2789
		Other	.8325	1.57676	1.000	-3.7612	5.4262
	Hindu	No Religion	.4054	1.36289	1.000	-3.4949	4.3058
		Atheist	.1042	1.43313	1.000	-4.0487	4.2571
		Christian	-.4188	1.34977	1.000	-4.2789	3.4413

		Other	.4137	1.64376	1.000	-4.3609	5.1883
	Other	No Religion	-.0082	1.58800	1.000	-4.6333	4.6169
		Atheist	-.3095	1.64868	1.000	-5.1302	4.5111
		Christian	-.8325	1.57676	1.000	-5.4262	3.7612
		Hindu	-.4137	1.64376	1.000	-5.1883	4.3609
TotalResil	No Religion	Atheist	-1.4071	1.16605	.918	-4.8057	1.9916
		Christian	.5312	1.01555	1.000	-2.3687	3.4310
		Hindu	-.3446	.98773	1.000	-3.1703	2.4812
		Other	-.4368	1.29747	1.000	-4.2201	3.3464
	Atheist	No Religion	1.4071	1.16605	.918	-1.9916	4.8057
		Christian	1.9382	1.14895	.621	-1.4135	5.2900
		Hindu	1.0625	1.12443	.983	-2.2291	4.3541
		Other	.9702	1.40434	.998	-3.1328	5.0733
	Christian	No Religion	-.5312	1.01555	1.000	-3.4310	2.3687
		Atheist	-1.9382	1.14895	.621	-5.2900	1.4135

		Hindu	-.8757	.96749	.988	-3.6400	1.8886
		Other	-.9680	1.28212	.997	-4.7101	2.7741
	Hindu	No Religion	.3446	.98773	1.000	-2.4812	3.1703
		Atheist	-1.0625	1.12443	.983	-4.3541	2.2291
		Christian	.8757	.96749	.988	-1.8886	3.6400
		Other	-.0923	1.26020	1.000	-3.7808	3.5963
	Other	No Religion	.4368	1.29747	1.000	-3.3464	4.2201
		Atheist	-.9702	1.40434	.998	-5.0733	3.1328
		Christian	.9680	1.28212	.997	-2.7741	4.7101
		Hindu	.0923	1.26020	1.000	-3.5963	3.7808

Based on observed means.

The error term is Mean Square(Error) = 26.221.

*. The mean difference is significant at the .05 level.

3) Can any differences between Faith and non-Faith community's propensity towards suicidality be explained through the elements of 'religiosity' and 'spirituality'?

Religious Attachment

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalRelComit	1	80	10.4625	3.01869	.33750
	2	144	15.2778	3.72563	.31047

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalRelComit	Equal variances assumed	1.456	.229	-9.893	222	.000	-4.81528	.48673	-5.77448	-3.85608
	Equal variances not assumed			-10.500	192.946	.000	-4.81528	.45858	-5.71976	-3.91080

Descriptives

TotalRelComit

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	55	10.5273	2.96182	.39937	9.7266	11.3280	6.00	18.00
Atheist	25	10.3200	3.19792	.63958	9.0000	11.6400	5.00	17.00
Christian	63	14.6190	4.25944	.53664	13.5463	15.6918	4.00	21.00
Hindu	50	15.4200	3.32025	.46955	14.4764	16.3636	5.00	21.00
Other	31	16.3871	2.90606	.52194	15.3211	17.4530	11.00	21.00
Total	224	13.5580	4.18048	.27932	13.0076	14.1085	4.00	21.00

Test of Homogeneity of Variances

TotalRelComit

Levene Statistic	df1	df2	Sig.
2.037	4	219	.090

ANOVA

TotalRelComit

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1259.704	4	314.926	26.149	.000
Within Groups	2637.541	219	12.044		
Total	3897.246	223			

Multiple Comparisons

Dependent Variable: TotalRelComit
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Religion	Atheist	.20727	.83709	.999	-2.0953	2.5098
	Christian	-4.09177*	.64042	.000	-5.8533	-2.3302
	Hindu	-4.89273*	.67812	.000	-6.7580	-3.0275
	Other	-5.85982*	.77941	.000	-8.0037	-3.7160
Atheist	No Religion	-.20727	.83709	.999	-2.5098	2.0953
	Christian	-4.29905*	.82031	.000	-6.5554	-2.0427
	Hindu	-5.10000*	.85007	.000	-7.4382	-2.7618
	Other	-6.06710*	.93287	.000	-8.6331	-3.5011
Christian	No Religion	4.09177*	.64042	.000	2.3302	5.8533
	Atheist	4.29905*	.82031	.000	2.0427	6.5554
	Hindu	-.80095	.65730	.741	-2.6089	1.0070
	Other	-1.76805	.76136	.142	-3.8623	.3262
Hindu	No Religion	4.89273*	.67812	.000	3.0275	6.7580
	Atheist	5.10000*	.85007	.000	2.7618	7.4382
	Christian	.80095	.65730	.741	-1.0070	2.6089
	Other	-.96710	.79333	.740	-3.1493	1.2151
Other	No Religion	5.85982*	.77941	.000	3.7160	8.0037
	Atheist	6.06710*	.93287	.000	3.5011	8.6331
	Christian	1.76805	.76136	.142	-.3262	3.8623
	Hindu	.96710	.79333	.740	-1.2151	3.1493

*. The mean difference is significant at the 0.05 level.

TotalRelComit

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05	
		1	2
Atheist	25	10.3200	
No Religion	55	10.5273	
Christian	63		14.6190
Hindu	50		15.4200
Other	31		16.3871
Sig.		.999	.160

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 39.584.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalRelInv	1	75	14.7200	5.04724	.58280
	2	143	39.8601	14.81843	1.23918

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalRelInv	Equal variances assumed	83.750	.000	-14.252	216	.000	-25.14014	1.76399	-28.61697	-21.66331
	Equal variances not assumed			-18.359	193.591	.000	-25.14014	1.36939	-27.84098	-22.43930

Descriptives

TotalRelInv

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	53	15.4717	5.45472	.74926	13.9682	16.9752	11.00	34.00
Atheist	22	12.9091	3.35104	.71444	11.4233	14.3949	11.00	24.00
Christian	62	38.5323	17.15954	2.17926	34.1746	42.8900	13.00	71.00
Hindu	50	42.0600	11.29098	1.59679	38.8511	45.2689	23.00	68.00
Other	31	38.9677	14.82899	2.66337	33.5284	44.4071	12.00	66.00
Total	218	31.2110	17.19504	1.16460	28.9156	33.5064	11.00	71.00

Test of Homogeneity of Variances

TotalRelInv

Levene Statistic	df1	df2	Sig.
28.692	4	213	.000

ANOVA

TotalRelInv

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	31572.045	4	7893.011	51.589	.000
Within Groups	32588.249	213	152.996		
Total	64160.294	217			

Multiple Comparisons

Dependent Variable: TotalRelInv
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Religion	Atheist	2.56261	3.13705	.925	-6.0683	11.1935
	Christian	-23.06056*	2.31396	.000	-29.4269	-16.6942
	Hindu	-26.58830*	2.43858	.000	-33.2975	-19.8791
	Other	-23.49604*	2.79680	.000	-31.1908	-15.8012
Atheist	No Religion	-2.56261	3.13705	.925	-11.1935	6.0683
	Christian	-25.62317*	3.06954	.000	-34.0684	-17.1780
	Hindu	-29.15091*	3.16454	.000	-37.8575	-20.4443
	Other	-26.05865*	3.44815	.000	-35.5455	-16.5718
Christian	No Religion	23.06056*	2.31396	.000	16.6942	29.4269
	Atheist	25.62317*	3.06954	.000	17.1780	34.0684
	Hindu	-3.52774	2.35109	.563	-9.9963	2.9408
	Other	-.43548	2.72086	1.000	-7.9213	7.0504
Hindu	No Religion	26.58830*	2.43858	.000	19.8791	33.2975
	Atheist	29.15091*	3.16454	.000	20.4443	37.8575
	Christian	3.52774	2.35109	.563	-2.9408	9.9963
	Other	3.09226	2.82760	.810	-4.6873	10.8718
Other	No Religion	23.49604*	2.79680	.000	15.8012	31.1908
	Atheist	26.05865*	3.44815	.000	16.5718	35.5455
	Christian	.43548	2.72086	1.000	-7.0504	7.9213
	Hindu	-3.09226	2.82760	.810	-10.8718	4.6873

*. The mean difference is significant at the 0.05 level.

TotalRelInv

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05	
		1	2
Atheist	22	12.9091	
No Religion	53	15.4717	
Christian	62		38.5323
Other	31		38.9677
Hindu	50		42.0600
Sig.		.897	.729

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 37.676.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Religious Support

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalRelSupport	1	79	6.9114	3.27848	.36886
	2	143	15.4266	8.09320	.67679

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalRelSupport	Equal variances assumed	128.830	.000	-8.948	220	.000	-8.51518	.95168	-10.39075	-6.63961
	Equal variances not assumed			-11.048	205.827	.000	-8.51518	.77078	-10.03481	-6.99555

Descriptives

TotalRelSupport

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	54	7.3333	3.90452	.53134	6.2676	8.3991	6.00	21.00
Atheist	25	6.0000	.00000	.00000	6.0000	6.0000	6.00	6.00
Christian	62	15.2097	8.60449	1.09277	13.0245	17.3948	6.00	30.00
Hindu	50	16.3600	7.40314	1.04696	14.2560	18.4640	6.00	30.00
Other	31	14.3548	8.19979	1.47273	11.3471	17.3625	6.00	29.00
Total	222	12.3964	7.91045	.53091	11.3501	13.4427	6.00	30.00

Test of Homogeneity of Variances

TotalRelSupport

Levene Statistic	df1	df2	Sig.
38.950	4	217	.000

ANOVA

TotalRelSupport

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	3802.226	4	950.557	20.572	.000
Within Groups	10026.891	217	46.207		
Total	13829.117	221			

Multiple Comparisons

Dependent Variable: TotalRelSupport
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
No Religion	Atheist	1.33333	1.64437	.927	-3.1901	5.8568
	Christian	-7.87634*	1.26529	.000	-11.3570	-4.3957
	Hindu	-9.02667*	1.33410	.000	-12.6966	-5.3568
	Other	-7.02151*	1.53174	.000	-11.2351	-2.8079
Atheist	No Religion	-1.33333	1.64437	.927	-5.8568	3.1901
	Christian	-9.20968*	1.61045	.000	-13.6398	-4.7796
	Hindu	-10.36000*	1.66506	.000	-14.9403	-5.7797
	Other	-8.35484*	1.82724	.000	-13.3813	-3.3284
Christian	No Religion	7.87634*	1.26529	.000	4.3957	11.3570
	Atheist	9.20968*	1.61045	.000	4.7796	13.6398
	Hindu	-1.15032	1.29206	.900	-4.7046	2.4039
	Other	.85484	1.49526	.979	-3.2584	4.9681
Hindu	No Religion	9.02667*	1.33410	.000	5.3568	12.6966
	Atheist	10.36000*	1.66506	.000	5.7797	14.9403
	Christian	1.15032	1.29206	.900	-2.4039	4.7046
	Other	2.00516	1.55392	.697	-2.2695	6.2798
Other	No Religion	7.02151*	1.53174	.000	2.8079	11.2351
	Atheist	8.35484*	1.82724	.000	3.3284	13.3813
	Christian	-.85484	1.49526	.979	-4.9681	3.2584
	Hindu	-2.00516	1.55392	.697	-6.2798	2.2695

*. The mean difference is significant at the 0.05 level.

TotalRelSupport

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05	
		1	2
Atheist	25	6.0000	
No Religion	54	7.3333	
Other	31		14.3548
Christian	62		15.2097
Hindu	50		16.3600
Sig.		.907	.686

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 39.399.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Negative Religious Support

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
How often do the people in your congregation make too many demands on you?	1	80	1.13	.537	.060
	2	143	1.91	.978	.082
How often are the people in your congregation critical of you and the things you do?	1	79	1.14	.593	.067
	2	145	2.04	1.123	.093

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference Lower	Upper
How often do the people in your congregation make too many demands on you?	Equal variances assumed	37.963	.000	-6.630	221	.000	-.784	.118	-1.017	-.551
	Equal variances not assumed			-7.730	220.945	.000	-.784	.101	-.984	-.584
How often are the people in your congregation critical of you and the things you do?	Equal variances assumed	39.421	.000	-6.645	222	.000	-.902	.136	-1.170	-.635
	Equal variances not assumed			-7.863	221.844	.000	-.902	.115	-1.128	-.676

Descriptive Statistics

	What is your religion?	Mean	Std. Deviation	N
How often do the people in your congregation make too many demands on you?	No Religion	1.19	.646	54
	Atheist	1.00	.000	25
	Christian	1.85	.938	62
	Hindu	2.06	1.096	50
	Other	1.77	.845	31
	Total	1.63	.927	222
How often are the people in your congregation critical of you and the things you do?	No Religion	1.20	.711	54
	Atheist	1.00	.000	25
	Christian	1.77	.818	62
	Hindu	2.24	1.271	50
	Other	2.26	1.316	31
	Total	1.72	1.061	222

Box's Test of Equality of Covariance Matrices[a]

Box's M	50.794
F	5.530
df1	9
df2	168889.466
Sig.	.000

Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.

a. Design: Intercept + Q14

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.777	376.266[b]	2.000	216.000	.000
	Wilks' Lambda	.223	376.266[b]	2.000	216.000	.000
	Hotelling's Trace	3.484	376.266[b]	2.000	216.000	.000
	Roy's Largest Root	3.484	376.266[b]	2.000	216.000	.000
Q14	Pillai's Trace	.265	8.289	8.000	434.000	.000
	Wilks' Lambda	.747	8.496[b]	8.000	432.000	.000
	Hotelling's Trace	.324	8.702	8.000	430.000	.000
	Roy's Largest Root	.265	14.365[c]	4.000	217.000	.000

a. Design: Intercept + Q14

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Levene's Test of Equality of Error Variances[a]

	F	df1	df2	Sig.
How often do the people in your congregation make too many demands on you?	12.267	4	217	.000
How often are the people in your congregation critical of you and the things you do?	21.341	4	217	.000

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Q14

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	How often do the people in your congregation make too many demands on you?	33.631[a]	4	8.408	11.689	.000

	How often are the people in your congregation critical of you and the things you do?	50.031[b]	4	12.508	13.663	.000
Intercept	How often do the people in your congregation make too many demands on you?	488.578	1	488.578	679.272	.000
	How often are the people in your congregation critical of you and the things you do?	566.105	1	566.105	618.388	.000
Q14	How often do the people in your congregation make too many demands on you?	33.631	4	8.408	11.689	.000
	How often are the people in your congregation critical of you and the things you do?	50.031	4	12.508	13.663	.000
Error	How often do the people in your congregation make too many demands on you?	156.081	217	.719		
	How often are the people in your congregation critical of you and the things you do?	198.653	217	.915		
Total	How often do the people in your congregation make too many demands on you?	780.000	222			

	How often are the people in your congregation critical of you and the things you do?	906.000	222			
Corrected Total	How often do the people in your congregation make too many demands on you?	189.712	221			
	How often are the people in your congregation critical of you and the things you do?	248.685	221			

a. R Squared = .177 (Adjusted R Squared = .162)
b. R Squared = .201 (Adjusted R Squared = .186)

Multiple Comparisons

Dunnett T3

Dependent Variable	(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
How often do the people in your congregation make too many demands on you?	No Religion	Atheist	.19	.088	.323	-.07	.44
		Christian	-.67*	.148	.000	-1.09	-.25
		Hindu	-.87*	.178	.000	-1.39	-.36
		Other	-.59*	.175	.015	-1.10	-.08
	Atheist	No Religion	-.19	.088	.323	-.44	.07
		Christian	-.85*	.119	.000	-1.20	-.51
		Hindu	-1.06*	.155	.000	-1.51	-.61
		Other	-.77*	.152	.000	-1.23	-.32
	Christian	No Religion	.67*	.148	.000	.25	1.09
		Atheist	.85*	.119	.000	.51	1.20
		Hindu	-.21	.195	.967	-.76	.35
		Other	.08	.193	1.000	-.48	.64
	Hindu	No Religion	.87*	.178	.000	.36	1.39
		Atheist	1.06*	.155	.000	.61	1.51
		Christian	.21	.195	.967	-.35	.76
		Other	.29	.217	.870	-.34	.91
	Other	No Religion	.59*	.175	.015	.08	1.10
		Atheist	.77*	.152	.000	.32	1.23
		Christian	-.08	.193	1.000	-.64	.48
		Hindu	-.29	.217	.870	-.91	.34
How often are the people in your congregation critical of you and the things you do?	No Religion	Atheist	.20	.097	.322	-.08	.49
		Christian	-.57*	.142	.001	-.98	-.17
		Hindu	-1.04*	.204	.000	-1.62	-.45
		Other	-1.05*	.255	.002	-1.81	-.30
	Atheist	No Religion	-.20	.097	.322	-.49	.08
		Christian	-.77*	.104	.000	-1.08	-.47
		Hindu	-1.24*	.180	.000	-1.77	-.71
		Other	-1.26*	.236	.000	-1.97	-.55
	Christian	No Religion	.57*	.142	.001	.17	.98
		Atheist	.77*	.104	.000	.47	1.08
		Hindu	-.47	.208	.239	-1.06	.13
		Other	-.48	.258	.482	-1.24	.28
	Hindu	No Religion	1.04*	.204	.000	.45	1.62
		Atheist	1.24*	.180	.000	.71	1.77
		Christian	.47	.208	.239	-.13	1.06
		Other	-.02	.297	1.000	-.88	.84
	Other	No Religion	1.05*	.255	.002	.30	1.81
		Atheist	1.26*	.236	.000	.55	1.97
		Christian	.48	.258	.482	-.28	1.24
		Hindu	.02	.297	1.000	-.84	.88

Based on observed means.
The error term is Mean Square(Error) = .915.
*. The mean difference is significant at the .05 level.

Religious Coping

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalRelPosCope	1	79	3.4937	1.08455	.12202
	2	143	8.1748	3.01712	.25230

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
TotalRelPosCope	Equal variances assumed	112.735	.000	-13.312	220	.000	-4.68115	.35165	-5.37419	-3.98812
	Equal variances not assumed			-16.703	196.613	.000	-4.68115	.28026	-5.23386	-4.12845

Descriptives

TotalRelPosCope

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	54	3.5741	1.23780	.16844	3.2362	3.9119	3.00	10.00
Atheist	25	3.3200	.62716	.12543	3.0611	3.5789	3.00	5.00
Christian	62	7.7258	3.21456	.40825	6.9095	8.5422	3.00	12.00
Hindu	51	8.6863	2.64945	.37100	7.9411	9.4314	3.00	12.00
Other	30	8.2333	3.13691	.57272	7.0620	9.4047	3.00	12.00
Total	222	6.5090	3.36302	.22571	6.0642	6.9538	3.00	12.00

Test of Homogeneity of Variances

TotalRelPosCope

Levene Statistic	df1	df2	Sig.
33.047	4	217	.000

ANOVA

TotalRelPosCope

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1142.153	4	285.538	45.650	.000
Within Groups	1357.329	217	6.255		
Total	2499.482	221			

Multiple Comparisons

Dependent Variable: TotalRelPosCope
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Religion	Atheist	.25407	.60501	.993	-1.4102	1.9184
	Christian	-4.15173*	.46553	.000	-5.4323	-2.8711
	Hindu	-5.11220*	.48834	.000	-6.4556	-3.7688
	Other	-4.65926*	.56950	.000	-6.2259	-3.0926
Atheist	No Religion	-.25407	.60501	.993	-1.9184	1.4102
	Christian	-4.40581*	.59252	.000	-6.0358	-2.7759
	Hindu	-5.36627*	.61061	.000	-7.0460	-3.6866
	Other	-4.91333*	.67727	.000	-6.7764	-3.0503
Christian	No Religion	4.15173*	.46553	.000	2.8711	5.4323
	Atheist	4.40581*	.59252	.000	2.7759	6.0358
	Hindu	-.96047	.47279	.255	-2.2611	.3401
	Other	-.50753	.55622	.892	-2.0376	1.0226
Hindu	No Religion	5.11220*	.48834	.000	3.7688	6.4556
	Atheist	5.36627*	.61061	.000	3.6866	7.0460
	Christian	.96047	.47279	.255	-.3401	2.2611
	Other	.45294	.57545	.934	-1.1300	2.0359
Other	No Religion	4.65926*	.56950	.000	3.0926	6.2259
	Atheist	4.91333*	.67727	.000	3.0503	6.7764
	Christian	.50753	.55622	.892	-1.0226	2.0376
	Hindu	-.45294	.57545	.934	-2.0359	1.1300

*. The mean difference is significant at the 0.05 level.

TotalRelPosCope

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05 1	Subset for alpha = 0.05 2
Atheist	25	3.3200	
No Religion	54	3.5741	
Christian	62		7.7258
Other	30		8.2333
Hindu	51		8.6863
Sig.		.992	.436

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 39.188.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Negative Religious Coping

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	1	79	1.06	.293	.033
	2	145	1.46	.790	.066
I wonder whether God has abandoned me.	1	80	1.03	.224	.025
	2	145	1.34	.699	.058

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	Equal variances assumed	76.294	.000	-4.247	222	.000	-.392	.092	-.574	-.210
	Equal variances not assumed			-5.336	201.996	.000	-.392	.073	-.537	-.247
I wonder whether God has abandoned me.	Equal variances assumed	71.172	.000	-3.890	223	.000	-.313	.080	-.471	-.154
	Equal variances not assumed			-4.949	190.387	.000	-.313	.063	-.438	-.188

Descriptive Statistics

	What is your religion?	Mean	Std. Deviation	N
I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	No Religion	1.09	.351	54
	Atheist	1.00	.000	25
	Christian	1.21	.513	63
	Hindu	1.73	.918	51
	Other	1.52	.890	31
	Total	1.32	.685	224
I wonder whether God has abandoned me.	No Religion	1.04	.272	54
	Atheist	1.00	.000	25
	Christian	1.14	.396	63
	Hindu	1.47	.809	51
	Other	1.52	.890	31
	Total	1.23	.597	224

Box's Test of Equality of Covariance Matrices[a]

Box's M	162.857
F	17.732
df1	9
df2	167496.189
Sig.	.000

Tests the null hypothesis that the observed covariance matrices of the dependent variables are equal across groups.

a. Design: Intercept + Q14

Multivariate Tests[a]

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.840	572.297[b]	2.000	218.000	.000	.840
	Wilks' Lambda	.160	572.297[b]	2.000	218.000	.000	.840
	Hotelling's Trace	5.250	572.297[b]	2.000	218.000	.000	.840
	Roy's Largest Root	5.250	572.297[b]	2.000	218.000	.000	.840
Q14	Pillai's Trace	.181	5.435	8.000	438.000	.000	.090
	Wilks' Lambda	.822	5.617[b]	8.000	436.000	.000	.093
	Hotelling's Trace	.214	5.798	8.000	434.000	.000	.097
	Roy's Largest Root	.199	10.873[c]	4.000	219.000	.000	.166

a. Design: Intercept + Q14

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Levene's Test of Equality of Error Variances[a]

	F	df1	df2	Sig.
I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	23.477	4	219	.000
I wonder whether God has abandoned me.	29.790	4	219	.000

Tests the null hypothesis that the error variance of the dependent variable is equal across groups.

a. Design: Intercept + Q14

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	15.742[a]	4	3.936	9.711	.000	.151
	I wonder whether God has abandoned me.	9.300[b]	4	2.325	7.265	.000	.117
Intercept	I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	338.823	1	338.823	836.051	.000	.792
	I wonder whether God has abandoned me.	301.187	1	301.187	941.101	.000	.811

Q14	I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	15.742	4	3.936	9.711	.000	.151
	I wonder whether God has abandoned me.	9.300	4	2.325	7.265	.000	.117
Error	I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	88.753	219	.405			
	I wonder whether God has abandoned me.	70.088	219	.320			
Total	I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	493.000	224				
	I wonder whether God has abandoned me.	417.000	224				

Corrected Total	I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	104.496	223				
	I wonder whether God has abandoned me.	79.388	223				

a. R Squared = .151 (Adjusted R Squared = .135)

b. R Squared = .117 (Adjusted R Squared = .101)

Multiple Comparisons

Dunnett T3

Dependent Variable	(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality.	No Religion	Atheist	.09	.048	.434	-.05	.23
		Christian	-.11	.080	.816	-.34	.12
		Hindu	-.63*	.137	.000	-1.03	-.24
		Other	-.42	.167	.139	-.92	.07
	Atheist	No Religion	-.09	.048	.434	-.23	.05
		Christian	-.21*	.065	.022	-.39	-.02
		Hindu	-.73*	.129	.000	-1.10	-.35
		Other	-.52*	.160	.029	-1.00	-.04
	Christian	No Religion	.11	.080	.816	-.12	.34
		Atheist	.21*	.065	.022	.02	.39
		Hindu	-.52*	.144	.006	-.93	-.10
		Other	-.31	.172	.540	-.82	.20
	Hindu	No Religion	.63*	.137	.000	.24	1.03
		Atheist	.73*	.129	.000	.35	1.10
		Christian	.52*	.144	.006	.10	.93
		Other	.21	.205	.972	-.38	.80
	Other	No Religion	.42	.167	.139	-.07	.92
		Atheist	.52*	.160	.029	.04	1.00
		Christian	.31	.172	.540	-.20	.82
		Hindu	-.21	.205	.972	-.80	.38
I wonder whether God has abandoned me.	No Religion	Atheist	.04	.037	.975	-.07	.14
		Christian	-.11	.062	.606	-.28	.07
		Hindu	-.43*	.119	.006	-.78	-.09
		Other	-.48	.164	.058	-.97	.01
	Atheist	No Religion	-.04	.037	.975	-.14	.07
		Christian	-.14	.050	.055	-.29	.00
		Hindu	-.47*	.113	.001	-.80	-.14
		Other	-.52*	.160	.029	-1.00	-.04
	Christian	No Religion	.11	.062	.606	-.07	.28
		Atheist	.14	.050	.055	.00	.29
		Hindu	-.33	.124	.094	-.68	.03
		Other	-.37	.167	.264	-.87	.12
	Hindu	No Religion	.43*	.119	.006	.09	.78
		Atheist	.47*	.113	.001	.14	.80
		Christian	.33	.124	.094	-.03	.68
		Other	-.05	.196	1.000	-.61	.52
	Other	No Religion	.48	.164	.058	-.01	.97
		Atheist	.52*	.160	.029	.04	1.00
		Christian	.37	.167	.264	-.12	.87
		Hindu	.05	.196	1.000	-.52	.61

Based on observed means.

The error term is Mean Square(Error) = .320.

*. The mean difference is significant at the .05 level.

Religious Forgiveness

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
It is easy for me to admit that I am wrong.	1	79	2.89	.698	.079
	2	145	3.15	.680	.057
I believe that God has forgiven me for things I have done wrong.	1	78	1.22	.677	.077
	2	143	2.94	1.043	.087
I believe that there are times when God has punished me.	1	78	1.08	.313	.035
	2	144	1.73	.855	.071
I often feel that no matter what I do now, I will never make up for the mistake I have made in the past.	1	80	1.69	.805	.090
	2	145	2.03	1.037	.086
I am able to make up pretty easily with friends who have hurt me in some way.	1	80	2.88	.624	.070
	2	145	2.87	.819	.068
I believe that when people say they forgive me for something I did, they really mean it.	1	80	2.95	.778	.087
	2	143	2.91	.830	.069
If I hear a sermon, I usually think about things I have done wrong.	1	80	1.28	.711	.080
	2	145	2.72	1.279	.106
I have grudges which I have held onto for months or years.	1	79	2.05	.749	.084
	2	144	2.00	.877	.073
I have forgiven myself for things that I have done wrong.	1	80	2.84	.834	.093
	2	144	2.78	.848	.071
I often feel like I have failed to live the right kind of life	1	80	1.74	.823	.092
	2	145	2.10	.915	.076

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
It is easy for me to admit that I am wrong.	Equal variances assumed	.188	.665	-2.767	222	.006	-.266	.096	-.455	-.076
	Equal variances not assumed			-2.746	156.936	.007	-.266	.097	-.457	-.075
I believe that God has forgiven me for things I have done wrong.	Equal variances assumed	30.086	.000	-13.121	219	.000	-1.719	.131	-1.977	-1.461
	Equal variances not assumed			-14.806	212.381	.000	-1.719	.116	-1.948	-1.490
I believe that there are times when God has punished me.	Equal variances assumed	102.506	.000	-6.503	220	.000	-.652	.100	-.850	-.455
	Equal variances not assumed			-8.200	199.810	.000	-.652	.080	-.809	-.495
I often feel that no matter what I do now, I will never make up for the mistake I have made in the past.	Equal variances assumed	5.441	.021	-2.592	223	.010	-.347	.134	-.611	-.083
	Equal variances not assumed			-2.786	198.563	.006	-.347	.125	-.593	-.101
I am able to make up pretty easily with friends who have hurt me in some way.	Equal variances assumed	7.168	.008	.057	223	.954	.006	.105	-.201	.213
	Equal variances not assumed			.062	200.917	.951	.006	.097	-.186	.198
I believe that when people say they forgive me for something I did, they really mean it.	Equal variances assumed	.848	.358	.361	221	.718	.041	.113	-.182	.264
	Equal variances not assumed			.368	172.704	.714	.041	.111	-.179	.261
If I hear a sermon, I usually think about things I have done wrong.	Equal variances assumed	59.754	.000	-9.319	223	.000	-1.442	.155	-1.747	-1.137
	Equal variances not assumed			-10.873	222.976	.000	-1.442	.133	-1.704	-1.181
I have grudges which I have held onto for months or years.	Equal variances assumed	2.567	.111	.434	221	.665	.051	.117	-.180	.281
	Equal variances not assumed			.454	182.939	.651	.051	.112	-.170	.271
I have forgiven myself for things that I have done wrong.	Equal variances assumed	.351	.554	.508	222	.612	.060	.118	-.172	.291
	Equal variances not assumed			.511	165.743	.610	.060	.117	-.171	.291
I often feel like I have failed to live the right kind of life	Equal variances assumed	.116	.734	-2.917	223	.004	-.359	.123	-.602	-.117
	Equal variances not assumed			-3.009	178.142	.003	-.359	.119	-.595	-.124

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
Do you believe there is a life after death?	1	80	1.51	.675	.075
	2	145	2.60	.582	.048

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Do you believe there is a life after death?	Equal variances assumed	4.786	.030	-12.663	223	.000	-1.088	.086	-1.257	-.918
	Equal variances not assumed			-12.135	143.863	.000	-1.088	.090	-1.265	-.910

Descriptives

Do you believe there is a life after death?

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	55	1.60	.710	.096	1.41	1.79	1	3
Atheist	25	1.32	.557	.111	1.09	1.55	1	3
Christian	63	2.65	.544	.068	2.51	2.79	1	3
Hindu	51	2.49	.644	.090	2.31	2.67	1	3
Other	31	2.68	.541	.097	2.48	2.88	1	3
Total	225	2.21	.807	.054	2.11	2.32	1	3

Test of Homogeneity of Variances

Do you believe there is a life after death?

Levene Statistic	df1	df2	Sig.
3.722	4	220	.006

ANOVA

Do you believe there is a life after death?

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	63.283	4	15.821	42.201	.000
Within Groups	82.477	220	.375		
Total	145.760	224			

Multiple Comparisons

Dependent Variable: Do you believe there is a life after death?
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Religion	Atheist	.280	.148	.323	-.13	.69
	Christian	-1.051*	.113	.000	-1.36	-.74
	Hindu	-.890*	.119	.000	-1.22	-.56
	Other	-1.077*	.138	.000	-1.46	-.70
Atheist	No Religion	-.280	.148	.323	-.69	.13
	Christian	-1.331*	.145	.000	-1.73	-.93
	Hindu	-1.170*	.149	.000	-1.58	-.76
	Other	-1.357*	.165	.000	-1.81	-.90
Christian	No Religion	1.051*	.113	.000	.74	1.36
	Atheist	1.331*	.145	.000	.93	1.73
	Hindu	.161	.115	.633	-.16	.48
	Other	-.027	.134	1.000	-.40	.34
Hindu	No Religion	.890*	.119	.000	.56	1.22
	Atheist	1.170*	.149	.000	.76	1.58
	Christian	-.161	.115	.633	-.48	.16
	Other	-.187	.139	.665	-.57	.20
Other	No Religion	1.077*	.138	.000	.70	1.46
	Atheist	1.357*	.165	.000	.90	1.81
	Christian	.027	.134	1.000	-.34	.40
	Hindu	.187	.139	.665	-.20	.57

*. The mean difference is significant at the 0.05 level.

Do you believe there is a life after death?

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05 1	2
Atheist	25	1.32	
No Religion	55	1.60	
Hindu	51		2.49
Christian	63		2.65
Other	31		2.68
Sig.		.252	.652

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 39.708.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalRelImport	1	78	9.4744	2.31160	.26174
	2	143	15.6783	4.10187	.34302

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalRelImport	Equal variances assumed	30.245	.000	-12.325	219	.000	-6.20396	.50337	-7.19603	-5.21189
	Equal variances not assumed			-14.379	218.742	.000	-6.20396	.43147	-7.05433	-5.35359

Descriptives

TotalRelImport

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	54	9.7222	2.49086	.33896	9.0423	10.4021	5.00	15.00
Atheist	24	8.9167	1.76725	.36074	8.1704	9.6629	5.00	12.00
Christian	63	15.0794	4.69489	.59150	13.8970	16.2618	6.00	23.00
Hindu	51	16.0588	3.61890	.50675	15.0410	17.0767	5.00	22.00
Other	29	16.3103	3.41325	.63382	15.0120	17.6087	9.00	23.00
Total	221	13.4887	4.64329	.31234	12.8731	14.1043	5.00	23.00

Test of Homogeneity of Variances

TotalRelImport

Levene Statistic	df1	df2	Sig.
10.928	4	216	.000

ANOVA

TotalRelImport

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1994.921	4	498.730	39.197	.000
Within Groups	2748.300	216	12.724		
Total	4743.222	220			

Multiple Comparisons

Dependent Variable: TotalRelImport
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Religion	Atheist	.80556	.87508	.889	-1.6018	3.2129
	Christian	-5.35714*	.66150	.000	-7.1769	-3.5374
	Hindu	-6.33660*	.69649	.000	-8.2526	-4.4206
	Other	-6.58812*	.82120	.000	-8.8472	-4.3290
Atheist	No Religion	-.80556	.87508	.889	-3.2129	1.6018
	Christian	-6.16270*	.85564	.000	-8.5165	-3.8089
	Hindu	-7.14216*	.88297	.000	-9.5712	-4.7131
	Other	-7.39368*	.98433	.000	-10.1015	-4.6858
Christian	No Religion	5.35714*	.66150	.000	3.5374	7.1769
	Atheist	6.16270*	.85564	.000	3.8089	8.5165
	Hindu	-.97946	.67190	.591	-2.8278	.8689
	Other	-1.23098	.80044	.539	-3.4330	.9710
Hindu	No Religion	6.33660*	.69649	.000	4.4206	8.2526
	Atheist	7.14216*	.88297	.000	4.7131	9.5712
	Christian	.97946	.67190	.591	-.8689	2.8278
	Other	-.25152	.82959	.998	-2.5337	2.0307
Other	No Religion	6.58812*	.82120	.000	4.3290	8.8472
	Atheist	7.39368*	.98433	.000	4.6858	10.1015
	Christian	1.23098	.80044	.539	-.9710	3.4330
	Hindu	.25152	.82959	.998	-2.0307	2.5337

*. The mean difference is significant at the 0.05 level.

TotalRelImport

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05 1	Subset for alpha = 0.05 2
Atheist	24	8.9167	
No Religion	54	9.7222	
Christian	63		15.0794
Hindu	51		16.0588
Other	29		16.3103
Sig.		.860	.555

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 38.418.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Attitudes

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
Suicide is an acceptable means of ending life in some situations.	1	80	3.35	1.202	.134
	2	145	2.57	1.327	.110
Suicide can never be justified under any circumstances.	1	80	1.99	1.073	.120
	2	145	2.77	1.388	.115
People who are suicidal can always be helped.	1	79	3.23	1.187	.134
	2	145	3.81	.986	.082
Once someone has decided to commit suicide their decision can never be reversed.	1	80	1.76	.875	.098
	2	145	1.74	.896	.074
People attempt suicide because of deep internal conflicts relating to their thoughts and feelings.	1	80	3.81	.781	.087
	2	145	3.93	.863	.072
People attempt suicide because they are seeking revenge for wrongs done to them by others.	1	80	2.00	.928	.104
	2	145	2.50	.994	.083
People attempt suicide because they are being punished by a higher power.	1	79	1.27	.593	.067
	2	145	1.61	.843	.070

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Suicide is an acceptable means of ending life in some situations.	Equal variances assumed	4.972	.027	4.348	223	.000	.778	.179	.425	1.130
	Equal variances not assumed			4.474	176.986	.000	.778	.174	.435	1.121
Suicide can never be justified under any circumstances.	Equal variances assumed	18.934	.000	-4.384	223	.000	-.785	.179	-1.138	-.432
	Equal variances not assumed			-4.717	199.095	.000	-.785	.166	-1.113	-.457
People who are suicidal can always be helped.	Equal variances assumed	10.825	.001	-3.950	222	.000	-.586	.148	-.878	-.294
	Equal variances not assumed			-3.741	137.160	.000	-.586	.157	-.896	-.276
Once someone has decided to commit suicide their decision can never be reversed.	Equal variances assumed	.755	.386	.143	223	.887	.018	.124	-.226	.262
	Equal variances not assumed			.144	166.278	.886	.018	.123	-.225	.260
People attempt suicide because of deep internal conflicts relating to their thoughts and feelings.	Equal variances assumed	.010	.921	-1.019	223	.309	-.119	.116	-.348	.111
	Equal variances not assumed			-1.049	177.220	.296	-.119	.113	-.341	.104
People attempt suicide because they are seeking revenge for wrongs done to them by others.	Equal variances assumed	2.219	.138	-3.672	223	.000	-.497	.135	-.763	-.230
	Equal variances not assumed			-3.746	172.724	.000	-.497	.133	-.758	-.235
People attempt suicide because they are being punished by a higher power.	Equal variances assumed	23.664	.000	-3.254	222	.001	-.348	.107	-.559	-.137
	Equal variances not assumed			-3.598	207.882	.000	-.348	.097	-.539	-.157

Spirituality

Group Statistics

	Religious or Not	N	Mean	Std. Deviation	Std. Error Mean
TotalSpiritual	1	78	8.3077	4.51637	.51138
	2	143	17.5944	4.57679	.38273

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
TotalSpiritual	Equal variances assumed	.208	.648	-14.482	219	.000	-9.28671	.64125	-10.55053	-8.02289
	Equal variances not assumed			-14.539	160.171	.000	-9.28671	.63874	-10.54815	-8.02527

Descriptives

TotalSpiritual

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No Religion	55	8.8182	4.79618	.64672	7.5216	10.1148	5.00	20.00
Atheist	23	7.0870	3.56642	.74365	5.5447	8.6292	5.00	19.00
Christian	62	16.7258	4.86934	.61841	15.4892	17.9624	5.00	25.00
Hindu	50	18.0800	4.06498	.57488	16.9247	19.2353	5.00	25.00
Other	31	18.5484	4.58867	.82415	16.8652	20.2315	5.00	25.00
Total	221	14.3167	6.35961	.42779	13.4736	15.1598	5.00	25.00

Test of Homogeneity of Variances

TotalSpiritual

Levene Statistic	df1	df2	Sig.
1.820	4	216	.126

ANOVA

TotalSpiritual

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	4488.124	4	1122.031	54.960	.000
Within Groups	4409.704	216	20.415		
Total	8897.828	220			

Multiple Comparisons

Dependent Variable: TotalSpiritual
Tukey HSD

(I) What is your religion?	(J) What is your religion?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
No Religion	Atheist	1.73123	1.12197	.536	-1.3553	4.8177
	Christian	-7.90762*	.83694	.000	-10.2100	-5.6052
	Hindu	-9.26182*	.88289	.000	-11.6906	-6.8330
	Other	-9.73021*	1.01476	.000	-12.5218	-6.9386
Atheist	No Religion	-1.73123	1.12197	.536	-4.8177	1.3553
	Christian	-9.63885*	1.10313	.000	-12.6735	-6.6042
	Hindu	-10.99304*	1.13839	.000	-14.1247	-7.8614
	Other	-11.46143*	1.24345	.000	-14.8821	-8.0407
Christian	No Religion	7.90762*	.83694	.000	5.6052	10.2100
	Atheist	9.63885*	1.10313	.000	6.6042	12.6735
	Hindu	-1.35419	.85883	.514	-3.7168	1.0084
	Other	-1.82258	.99390	.357	-4.5568	.9116
Hindu	No Religion	9.26182*	.88289	.000	6.8330	11.6906
	Atheist	10.99304*	1.13839	.000	7.8614	14.1247
	Christian	1.35419	.85883	.514	-1.0084	3.7168
	Other	-.46839	1.03289	.991	-3.3098	2.3731
Other	No Religion	9.73021*	1.01476	.000	6.9386	12.5218
	Atheist	11.46143*	1.24345	.000	8.0407	14.8821
	Christian	1.82258	.99390	.357	-.9116	4.5568
	Hindu	.46839	1.03289	.991	-2.3731	3.3098

*. The mean difference is significant at the 0.05 level.

TotalSpiritual

Tukey HSD[a,b]

What is your religion?	N	Subset for alpha = 0.05 1	2
Atheist	23	7.0870	
No Religion	55	8.8182	
Christian	62		16.7258
Hindu	50		18.0800
Other	31		18.5484
Sig.		.449	.395

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 38.448.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.